Whitehall-Coplay School District

Emergency Action Plan ~ Seizures

Student: __________________________ Date: __________________________
Teacher/Classroom: __________________________ Bus: __________________________
Allergies: __________________________
Seizure type: __________________________
Description of signs and symptoms during seizure: __________________________

Daily Medications: __________________________

(medications/dosages)

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**Treatment**

**DO NOT PUT ANYTHING IN THE MOUTH**
* Cushion head, remove glasses
* Turn on side and keep airway clear
* Don't hold down

*Loosen tight clothing
*Note time seizure starts and length of time it lasts

Medications: __________________________

(medication/dose/route)

Call 9-911 if:
- Seizure does not stop within ______ minutes
- Child does not start to wake up within ______ minutes after seizure is over

**Following seizure:** (please check)
- Child should rest in nurse's office
- Child may return to class
- Parent/guardian should be notified

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**Emergency Calls**

1. Parent/guardian: __________________________

2. Additional emergency Contacts: __________________________
3. Physician: __________________________

Parent/Guardian Signature: __________________________ Date: __________________________
Physician Signature: __________________________ Date: __________________________
School Nurse: __________________________ Date: __________________________
School personnel informed: __________________________ Date: __________________________

*Care Plans are updated yearly and/or throughout the school year as needed.*
WHITEHALL-COPLAY SCHOOL DISTRICT

Medication Dispensing Form

To the Physician:

Please complete and sign this form if you request your patient to receive a medication during school hours. By signing this form, you are indicating that the student could not attend school unless this medication was available during the school day.

Medication must be brought in the original bottle and will be kept in the health room. It will be the student’s responsibility to request the medication in the health room.

Student’s name: ___________________________________________ Grade: ________ Teacher: ________________________________

Prescribed medication: ____________________________________

Dosage*, route, and frequency: ________________________________

Time of day to be given: ____________________________________

Reason for medication: ____________________________________

Side effects: _____________________________________________

Is child taking any other medication? Name? __________________

This authorization is in effect from: _____

_____ to: ________ **

☐ Student may carry INHALER / EPIPEN (circle choice) and use as prescribed by licensed provider.

*Licensed Prescriber signature: ____________________________ Date: __________________

Print name of Licensed Prescriber: _______________________

Telephone # of Licensed Prescriber: _______________________

I do hereby release, discharge, and hold harmless, the Whitehall-Coplay School District, its agents and employees, from any and all liability claim for the administration of the above medication to my child and for any and all injuries resulting there from. I consent for employees of Whitehall-Coplay School District to exchange information regarding this medication with the physician who ordered the medication. Please refer to the school calendar for policies related to medications.

Parent / Guardian signature: ____________________________ Date: __________________

*If the dosage is changed at any time, physician must complete new form. Please request additional forms as needed from the school nurse or obtain on-line at www.whitehallcoplay.org.

**This form is only valid for school year in which it was completed.
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