Whitehall-Coplay School District

Emergency Action Plan ~ Seizures

Place Child's Photo Here

Student: ____________________ Date:________

Teacher/Classroom:____________________ Bus: ________

Allergies:____________________

Seizure type: ____________________

Description of signs and symptoms during seizure:____________________

____

____

Daily Medications: ____________________

____

(medications/dosages)

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

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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