The Timothy School

Seizure Emergency Care Plan (Doctor Signature Required)

ONLY required for students who have been diagnosed with a seizure disorder

Student's Name: ______________________ **Date of Birth:** ______________

Action (Check boxes that apply)			
Time Seizure	☐	Move student to floor and protect head	☐
Check airway and breathing (If compromised, call 911)	☐	Remove any objects from students' proximity. Place on side. Do not hold down. Do not insert anything into mouth.	☐
Contact the School Nurse/Team A through front office	☐	Diastat (mg) rectally for single seizure lasting greater than (_ _)minutes	☐
Clonazepam 2mg/ml oral disintegrating tablet, give ___ml (________mg total) by mouth once as needed for cluster	☐	Valtoco Nasal Spray _________mg	☐
Call Parent	☐	Please note any restrictions:	☐
Other Comments: (Ex.-May Student remain in school?)			

Location of Emergency Medication			
N/A (no meds)	☐	In Nurses Office	☐
Carried with student when traveling off campus during school hours			☐

Emergency Contact Information	
Parent/Guardian #1	Cell Phone:
	Work Phone:
Parent/Guardian #2	Cell Phone:
	Work Phone:
Emergency Contact in above cannot be reached	Cell Phone:
	Work Phone:

______________________________ ______________________________
Prescribing Health Care Provider Name **Prescribing Health Care Provider Phone Number**

______________________________ ______________________________
Prescribing Health Care Provider Signature **Date of Signature**

______________________________ ______________________________
Parent(s)/Guardian Signature **Date of Signature**