North Branch Area
PUBLIC SCHOOLS
Independent School District #138

Emergency Health Care Plan

NAME: _____ Grade:____ D.O.B. _____SCHOOL YR: _____
PARENT/GUARDIAN NAME: _____Phone- Home: _____
Cell: _____Work:_____
MEDICAL DIAGNOSIS: **Seizure Disorder**_____
MEDICATIONS: _____
EMERGENCY HOSPITAL: _____ Phone:_____
Health Care Provider: _____Phone:_____

PLAN: Safety is the first priority. Remain Calm

Protect from injury:

DO NOT restrain child or put anything in the mouth!
If possible remove from wheelchair/desk and place on left side on a mat on the floor.
Cushion head and remove glasses.
Clear the areas of sharp, hard objects.
Loosen tight clothing.
Monitor airway. Do CPR **IF** needed.

Document what is observed. Note time of onset, duration, and who completed each intervention.

Begin timing the seizure immediately, call the Health Office for help and page RN.

Trained staff will assist with medications as prescribed/authorized by physician and provided by parent.
If **seizure lasts 3 minutes,** administer _____**.**

If Midazolam/Diastat is given, call 911.

Health office staff will then assess and report to parents.

If on the Bus—Call 911 and follow bus guidelines.

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I have read and agree that the above procedure should be followed in the event that my child has an emergency at school, or at a school activity. I understand that I am responsible for ensuring that emergency medications are available for my child, this includes when my child is at school, going to and from school, and while on field trips. I understand that I must provide a completed Authorization for Medication Form for any necessary medications before they can be given.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

☐ Medication/Physician Orders (Health Office/File)

The following received copies and/or are trained to initiate plan:

Parent/Guardian____ Health Office _____Para/Aide ___ Bus Garage_____.Teacher(s)_____Coach ____ Other ____.
**** Plan must be reviewed and signed **annually***** **Renewal Date:**_____