Endeavor Charter School

Physician's Plan of Treatment: Seizures

Name of Student: _____ Birthdate: _____

Emergency Family Contact Numbers:

(1) _____

(2) _____

Type of seizure:
What does the seizure look like and how long does it usually last? _____

_____

_____

Does the student require any protective equipment or activity restrictions? _____

_____

List medication needed at SCHOOL (name, dosage/route, and indications):

Administer _____ for a seizure episode lasting longer

than _____ minutes. Possible side effects: _____

***** PLEASE COMPLETE ATTACHED MEDICATION AUTHORIZATION FORM FOR ALL MEDICATIONS TO BE KEPT OR ADMINISTERED AT SCHOOL *****

HOME seizure medications: _____

*****EMS (911) WILL BE CALLED FOR ANY STUDENT WITHOUT A PRIOR HISTORY OF SEIZURES WHO HAS A FIRST SEIZURE EPISODE AT SCHOOL.*****

FOR STUDENTS WITH A KNOWN SEIZURE DISORDER, PLEASE INDICATE WHEN 911 SHOULD BE CALLED [Check one]:

[] If any seizure activity occurs.

[] Only if absence of breathing or pulse, seizure of 10 minutes or greater duration, multiple consecutive seizures which total 10 minutes or greater, pale/bluish skin or lips, or noisy breathing after seizure has stopped. Perform CPR for absent breathing or pulse.

[] Other: _____

[] IF GENERALIZED SEIZURE OCCURS:

1. If falling, assist student to floor, turn to side. Loosen clothing at neck and waist; protect head from injury. Clear away furniture and other objects from area.
2. Time the seizure. Stay with the student.
3. DO NOT restrain or insert anything into student's mouth. Do not try to stop purposeless behavior.
4. During a general or grand mal seizure expect to see pale or bluish discoloration of the skin or lips. Expect to hear noisy breathing.

[] IF SMALLER SEIZURE OCCURS (e.g., lip smacking, behavior outburst, staring, twitching of mouth or hands):

1. Assist student to comfortable, sitting position.
2. Time the seizure.
3. Stay with student.

WHEN SEIZURE COMPLETED:

1. Reorient and assure student. A period of sleepiness often follows a seizure.
2. A student recovering from a generalized seizure may manifest abnormal behavior such as incoherent speech, restlessness, and confusion.
3. Inform parent immediately if seizure activity occurs at school, unless indicated otherwise here: _____

Physician Signature:_____ Date:_____

Print Name:_____ Phone_____

I want this plan implemented for my child, in school. I hereby give my permission for exchange of confidential information contained in the record of my child between the ECS staff and physician.

Parent/Guardian Signature: _____

Date: _____ **Duration of order: Schoolyear _**

School staff instructed:_____ **Date:**_____

Parent Request and Physician's Order Form for Medication

To be completed by PARENT:

Child's Name:_____ Age: _____

I request that my child be administered the medication as indicated in the physician's order below. I understand that non-medical personnel conduct the administration. If an emergency injection is ordered, I give permission for the medical staff of Endeavor Charter School to instruct designated staff in the administration technique. I understand that it is my responsibility to transport the medication to school and to make school personnel aware of the need to transport medication on extended field trips away from Endeavor.

I understand that:

(1) No employees and agents of Endeavor Charter School shall be liable in civil damages to any party for any act authorized or for any omissions relating to that act, unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing.
(2) Information shared may be in the form of an emergency/individual care plan for my child and may include information provided by my child's physician, myself, or from records that have been released to the school from another agency.
(3) Exchange of information will be limited to the minimum necessary to provide the required assistance for my child and will be shared only with those staff who may need to provide the specific assistance for him/her.
(4) This consent to release information must be signed before my child's teachers can provide assistance with special medical needs other than notifying parents and activating emergency services (911).
(5) I assume responsibility for notifying my child's teacher of my child's medical condition. I may request instruction by members of the medical committee of the Endeavor Board of Directors in a medical procedure or technique.

I authorize:
The release and exchange of medical information between my child's physician and any representative of Endeavor Charter School that is necessary in carrying out services for my child.

Parent/Guardian Signature

Emergency Contact Number #1 Date

Emergency Contact Number #2

To be completed by PHYSICIAN:

Name and form of medication

Dosage and time to be given

Symptoms to be given for

Method of administration

Administration by: [] School personnel [] Student (please complete second page if student should carry or self-administer)

Significant side effects: _____ Duration of order

Telephone Physician's Name (please print/type) Physician Signature Date

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To be completed by SCHOOL:
I am aware of the above student's medication requirements as noted above and will administer the medication as directed.

Endeavor Staff Signature

Date