My Seizure Response Plan

Name: ______________________ Birth Date: ______________

Address: ______________________ Phone: ______________

1st Emergency Contact /Relation: ______________________ Phone: ______________

2nd Emergency Contact / Relation: ______________________ Phone: ______________

Seizure Information

Seizure Type/Nickname	What Happens	How Long It Lasts	How Often

Triggers

____

____

Daily Seizure Medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other Seizure Treatments

Device Type: ______________ Model: ______________ Serial# ______________ Date Implanted ______________

Dietary Therapy: ______________________ Date Begun: ______________

Special Instructions: ______________________

____

Other Therapy: ______________________

____

continued on back

Seizure First Aid

- Keep calm, provide reassurance, remove bystanders
- Keep airway clear, turn on side if possible, nothing in mouth
- Keep safe, remove objects, do not restrain
- Time, observe, record what happens
- Stay with person until recovered from seizure
- Other care needed: ______________________

Call 911 if...

- Generalized seizure longer than 5 minutes
- Two or more seizures without recovering between seizures
- "As needed" treatments don't work
- Injury occurs or is suspected, or seizure occurs in water
- Breathing, heart rate or behavior doesn't return to normal
- Unexplained fever or pain, hours or few days after a seizure
- Other care needed: ______________________

When Seizures Require Additional Help

Type of Emergency (long, clusters or repeated events)	Description	What to Do

"As Needed" Treatments (VNS magnet, medicines)

Name	Amount to Give	When to Give	How to Give

Health Care Contact

Epilepsy Doctor: ______________________ Phone: ______________________

Nurse/Other Health Care Provider: ______________________ Phone: ______________________

Preferred Hospital: ______________________ Phone: ______________________

Primary Care: ______________________ Phone: ______________________

Pharmacy: ______________________ Phone: ______________________

Special Instructions: ______________________

____

My signature ______________________ Date ______________________

Provider signature ______________________ Date ______________________

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ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

CHICAGO PUBLIC SCHOOLS

PARENT REQUEST FOR ADMINISTRATION OF MEDICATION TO A STUDENT

________________________	________________	______________
Name of Student	Birth Date	ID Number
________________________	________________	______________
Address	Telephone	Zip Code

I ________________________ (Mother, Father, Legal Guardian) of the above named student, give permission to the school nurse to administer medication as requested by my child's physician ________________________________ during school hours.

NAME OF PHYSICIAN

I will bring the medication to school nurse or principal/designee in original container appropriately labeled by the pharmacist or licensed provider.

____

Signature of Parent / Guardian

____

Address

____

City Zip

____

Home Phone Business Phone

____

Date

***This request is valid for 1 year from date of signature. Any change in medication or dose requires a new request form.**

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ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

CHICAGO PUBLIC SCHOOLS

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

Name of Student	Birth Date	ID Number
Address	Telephone Number	Zip Code

The above named student has ____
Name of Disease or Syndrome

I am requesting that the above named student be administered the following medication during school hours:

______________________________ ______________________________
Name of Medication | Type of Medication, i.e. Tablet, Liquid, Inhaler

______________________________ ______________________________
Dosage | Route | Time to be given

____
Possible Side Effects

The phone number where I may be reached in the event of a reaction to the medication or an emergency is:

Physician's Name______________________________ **Hospital Affiliation** ______________
(Please print or type)

Address ______________________________**Telephone #** __________**Fax #**__________

Physician's Signature ______________________________**Date** ______________

***This request is valid for 1 year from date of signature. Any change in medication or dose requires a new request form.**

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