WARWICK SCHOOL DISTRICT

Emergency Care Plan for Students with Seizures

Student's Name: _____ Grade/Teacher: _____

DOB: _____ Gender: M ___ F___ School: _____

Parent/Guardian Name: _____

Telephone: (home)_____ (work) _____ (cell) _____

Parent/Guardian Name: _____

Telephone: (home) _____ (work) _____ (cell) _____

Emergency Contact Name (if parent/guardian not available): _____

Telephone # for Emergency Contact: (home) _____ (work) _____ (cell) _____

Name of Healthcare Provider: _____ Telephone #: _____

1. **What type of seizures does your child have? (please describe) _____**

   _____

2. **At what age was your child first diagnosed with seizures? _____**

3. **What was the date of your child's last seizure? _____ How long did it last? _____**

4. **Describe your child's symptoms *before* the seizure _____**

   and *after* the seizure occurs: _____

5. **Is your child able to tell someone that a seizure is about to occur? (please describe) _____**

   _____

6. **Name of seizure medication: _____ Dose _____ Time Given _____**
   A signed order from the child's health care provider and written parent permission are required each school year for any medication to be administered at school. Please refer to WSD medication policy.

7. **Does your child have any activity restrictions or limitations? (please describe) _____**

   _____

8. **Please provide any other information that would be beneficial for your child at school. _____**

   _____

Note: **You are encouraged to alert all other school and after-school personnel (transportation, cafeteria, coaches, etc.) who may have contact with your child, so that they are aware of your child's diagnosis and treatment that may be needed.**

Parent/Guardian Signature: _____ Date: _____

Certified School Nurse Signature: _____ Date: _____