JOINT SCHOOL DISTRICT NO. 2
1303 E. CENTRAL DRIVE, MERIDIAN, IDAHO PHONE (208) 855-4500

SEIZURE DISORDER INFORMATION FORM

Student's Name _____ Date _____

Information Provided by:_____ Relationship:_____

Physician _____

Date last seen by physician_____

Type of Seizure Disorder _____

Seizure Description_____

_____

Medication (dose/frequency)_____

_____

Likelihood and Frequency of Seizures During School Hours _____

_____

Any Limitations Specified by Physician _____

_____

Other Information: _____

_____

_____

_____

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EMERGENCY SEIZURE TREATMENT

Student's Name _____ Age _____Weight _____

Seizure Types _____

- **Treatment Order:**
  - ☐ DIASTAT _____ mg rectally prn for: seizure > _____ minutes

    OR for _____ or more seizures in _____ (hour/min)
  - ☐ Use VNS (vagal nerve stimulator) magnet _____
  - ☐ Other _____
- **Call 911 if:**
  - ☐ Seizure does not stop by itself or with VNS within _____ minutes
  - ☐ Seizure does not stop within _____ minutes of administering DIASTAT
  - ☐ Child does not start to wake up within _____ minutes after seizure is over (no DIASTAT given)
  - ☐ Child does not start to wake up within _____ minutes after seizure is over (after DIASTAT given)
- **Following a seizure: (Please check)**
  - ☐ Child should rest in nurse's office
  - ☐ Child may return to class
  - ☐ Parent/Caregiver should be contacted immediately
  - ☐ Parent/caregiver should receive a copy of seizure record sent home with child

Parent Signature _____ Date _____

Physician Information:

Physician/Nurse Practitioner/Physician Assistant Name (Printed)_____

Signature_____ Date _____

Address _____

Phone Number_____ Fax_____

Revised Jul-14