Las Escuelas Públicas del Condado de Loudoun
Plan de Acción de Emergencia de Convulsiones/Orden de Médico

Pon Foto del Estudiante Aqui

Información del Estudiante

Apellido: _____ Nombre:_____ Fecha de Nacimiento:_____

ID # del Estudiante: _____ Escuela: _____ Grado: _____

Padre/Guardian: _____ Celular:_____ Año Escolar: _____

Seizure History To be completed by a Licensed Healthcare Provider (Physician, Physician's Assistant, or Nurse Practitioner)		
Seizure Type (Check all that apply)		
Generalized Non-Motor ☐ Absence seizure	**Generalized Motor:** ☐ Atonic (drop) ☐ Tonic/Clonic (grand mal) ☐ Myoclonic	**Focal Seizures** ☐ Focal Aware (simple partial) ☐ Focal Impaired (complex partial)
Description of Seizure		
Area of Body Involved:	Frequency:	Duration:
Seizure History / Medical Diagnosis:		

Seizure Triggers:

☐ Missed Seizure Medication ☐ Lack of Sleep ☐ Emotional Stress ☐ Physical Stress ☐ Missing Meals
☐ Alcohol / Drugs ☐ Flashing Lights ☐ Menstrual Cycle ☐ Illness with high fever
☐ Response to specific food, or excessive caffeine, specify: _____ ☐ Other, specify: _____

Warning Signs - Symptoms that signal a seizure may be starting:

☐ Headache ☐ Staring Spells ☐ Confusion ☐ Dizziness ☐ Change in Vision/Auras
☐ Sudden Feeling of Fear or Anxiety ☐ Strange Smell ☐ Other, specify: _____

Define Seizure Emergency	**Emergency Response Plan**	
A seizure emergency for this student is: ☐ **Continual seizure** lasting greater than _____ minutes ☐ **Cluster:** _____ (# seizures in) _____ minutes ☐ **Other** _____ _____ _____	**Medication/ Instructions/ Actions** **Continual seizure:** ☐ Administer _____ *(name of medication, dose, route)* ☐ Call 911 ✓ Notify Parent **Cluster seizure:** ☐ Administer _____ *(name of medication, dose, route)* ☐ Call 911 ✓ Notify Parent ☐ **Other:** _____ ☐ Call 911 ✓ Notify Parent	
	☐ Vagus Nerve Stimulator	Describe magnet use:

Healthcare Provider's Name (Print/stamp): _____

Healthcare Provider's Signature: _____ Date: _____

National Provider Identifier (NPI): _____ Phone: _____

Nombre del Padre/Guardian: _____ Teléfono: _____

Mi firma da permiso para el diseñado del director a seguir este plan, administrar medicamento de receta, y communicarse con el médico si necesario. Yo también acuerdo de recoger algún medicamento no usado al fin del año escolar. Yo entiendo que medicamento no recogido por un padre/guardian al fin del año escolar será tirado.

Firma del Padre/Guardian: _____ Fecha: _____

SEE REVERSE

Las Escuelas Públicas del Condado de Loudoun
Plan de Acción de Emergencia de Convulsiones/Orden de Médico
Pagina 2

To Be Completed with Health Office Staff
Medication received:_____ Expiration Date: _____
Medication received:_____ Expiration Date: _____
Medication received by:_____/ _____
Health Office Staff Signature/ Date Parent Signature/ Date