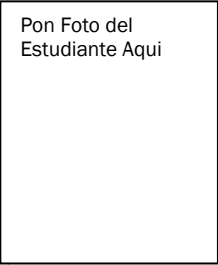


**Las Escuelas Públicas del Condado de Loudoun**  
**Plan de Acción de Emergencia de Convulsiones/Orden de Médico**

Pon Foto del Estudiante Aquí

**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)**

<p><b>Generalized Non-Motor</b></p> <input type="checkbox"/> Absence seizure	<p><b>Generalized Motor:</b></p> <input type="checkbox"/> Atonic (drop) <input type="checkbox"/> Tonic/Clonic (grand mal) <input type="checkbox"/> Myoclonic	<p><b>Focal Seizures</b></p> <input type="checkbox"/> Focal Aware (simple partial) <input type="checkbox"/> Focal Impaired (complex partial)
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**Description of Seizure**

Area of Body Involved: _____	Frequency: _____	Duration: _____
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**Seizure History / Medical Diagnosis:**

\_\_\_\_\_

**Seizure Triggers:**

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

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

<input type="checkbox"/> Headache	<input type="checkbox"/> Staring Spells	<input type="checkbox"/> Confusion	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Change in Vision/Auras
<input type="checkbox"/> Sudden Feeling of Fear or Anxiety		<input type="checkbox"/> Strange Smell	<input type="checkbox"/> Other, specify: _____	

Define Seizure Emergency	Emergency Response Plan		
<p><b>A seizure emergency for this student is:</b></p> <input type="checkbox"/> <b>Continual seizure</b> lasting greater than _____ minutes <input type="checkbox"/> <b>Cluster:</b> _____ (# seizures in) _____ minutes <input type="checkbox"/> <b>Other</b> _____	<p><b>Medication/ Instructions/ Actions</b></p> <p><b>Continual seizure:</b></p> <input type="checkbox"/> Administer _____ <small>(name of medication, dose, route)</small> <input type="checkbox"/> Call 911     ✓ Notify Parent <p><b>Cluster seizure:</b></p> <input type="checkbox"/> Administer _____ <small>(name of medication, dose, route)</small> <input type="checkbox"/> Call 911     ✓ Notify Parent <p><b>Other:</b></p> <p>_____</p> <input type="checkbox"/> Call 911     ✓ Notify Parent <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Vagus Nerve Stimulator</td> <td>Describe magnet use: _____</td> </tr> </table>	<input type="checkbox"/> Vagus Nerve Stimulator	Describe magnet use: _____
<input type="checkbox"/> 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 comunicarse 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: \_\_\_\_\_

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