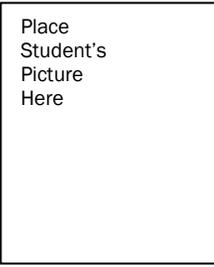


Loudoun County Public Schools

Seizure Action Plan / Physician's Order



Student's Information

Last Name: _____ First Name: _____ DOB: _____

Student ID # _____ School: _____ Grade: _____

Parent/Guardian: _____ Cell: _____ SY: _____

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 |
|---|---|
| <p>A seizure emergency for this student is:</p> <p><input type="checkbox"/> Continual seizure lasting greater than _____ minutes</p> <p><input type="checkbox"/> Cluster: _____ (# seizures in) _____ minutes</p> <p><input type="checkbox"/> Other _____</p> <p>_____</p> <p>_____</p> | <p>Medication/ Instructions/ Actions</p> <p>Continual seizure:</p> <p><input type="checkbox"/> Administer _____ <small>(name of medication, dose, route)</small> <input type="checkbox"/> Call 911 <input checked="" type="checkbox"/> Notify Parent</p> <p>Cluster seizure:</p> <p><input type="checkbox"/> Administer _____ <small>(name of medication, dose, route)</small> <input type="checkbox"/> Call 911 <input checked="" type="checkbox"/> Notify Parent</p> <p><input type="checkbox"/> Other:</p> <p>_____</p> <p><input type="checkbox"/> Call 911 <input checked="" type="checkbox"/> Notify Parent</p> <hr/> <p><input type="checkbox"/> Vagus Nerve Stimulator Describe magnet use: _____</p> |

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

Healthcare Provider's Signature: _____

Date: _____

National Provider Identifier (NPI): _____

Phone: _____

Parent/Guardian Name: _____ Phone: _____

My signature gives permission for principal's designee to follow this plan, administer prescribed medication, and contact healthcare provider if necessary. I also agree to pick up any unused medication at the end of the school year. I understand that medication not picked up by a parent/guardian at the end of the school year will be discarded.

Parent/Guardian Signature: _____ Date: _____

Loudoun County Public Schools
Seizure Action Plan / Physician's Order Page 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