## Santa Maria Joint Union High School District

| ERHS | SMHS | PVHS | Delta High School |
|---|---|---|---|
| 941 E. Foster Rd. | 901 S. Broadway | 675 Panther Drive | 251 E Clark Avenue |
| Santa Maria, Ca 93455 | Santa Maria, Ca 93454 | Santa Maria, Ca 93454 | Santa Maria,.Ca 93455 |
| 805-937-2051 | 805-925-2567 | 805-922-1305 | 805-937-6356 |
| Health office ext. 2718 | Health office ext. 3581 | Health office ext. 5753 | Fax # 805-934-4743 |
| Fax # 805-934-4981 | Fax # 805-922-0215 | Fax # 805-928-2543 | |


# SEIZURE TREATMENT ORDER FORM

1. Name of Student _____DOB_____
2. Diagnosis/Type of Seizure: _____
3. Seizure triggers or warning signs: _____
4. Student's reactions to seizure: _____
5. Treatment: Check box if applies

   [ ] Provide Basic Seizure First Aid (see box)
   [ ] Contact school nurse
   [ ] notify parent or contact person
   [ ] notify doctor / provide copy seizure log
   [ ] may rest in Health office or may go home
   [ ] activate VNS

   Daily medication taken at home: _____

**Basic Seizure First Aid:**
**Provide care and comfort**
* Stay calm & track time
* Keep child safe
* Do not restrain
* Stay with child until fully conscious
* Record seizure in log

***For Tonic-clonic (grand mal) seizure***
* Protect head
* keep airway open/watch breathing
* Turn child on side

_____

## EMERGENCY RESPONSE:

[ ] Administer emergency medication as indicated below (indicate route of administration)

_____

_____

[ ] For seizure longer than _____

[ ] cluster seizure for total duration of _____

[ ] **CALL 911** if

[ ] seizure duration longer than 5 minutes or _____
[ ] emergency medication is administered
[ ] significant change in vital signs

**A seizure is generally considered an Emergency when:**
*A convulsive (tonic-clonic) seizure last longer than 5 min.
*Students repeated seizure without regaining consciousness
*Student has a first time seizure
*Student is injured
* Student has diabetes
*Student has breathing difficulties
*Student has seizure in water

[ ] Other: _____

Special Consideration and Safety precaution _____

_____ _____ _____
Physician's Name and Signature Date Phone and Fax number

Please indicate duration of treatment: _____ [ ] Please send me a copy of Individualized Health Care Plan

**PARENT/GUARDIAN CONSENT FOR MANAGEMENT OF MEDICATION AT SCHOOL AND SPONSORED EVENTS**

I, the undersigned parent/guardian of the above named student, request that the prescribed medication be administered and/or assisted by trained school personnel to my child in accordance with the state laws and regulations. I will:

1. Provide the necessary supplies and equipment.
2. Notify the school nurse if there is any change in student health status or attending physician
3. Notify the school nurse immediately and provide new consent for any changes in doctor's orders.

Parent/Guardian Signature _____ Print Name _____ Date: _____

Reviewed by School Nurse _____ Date: _____