Word of Life Lutheran School

HEALTH SERVICES

3545 S. 23rd Street, Milwaukee, WI 53221 Phone (414) 281-7808 Fax (414) 281-8823

Student's Name:

School Attending:	**Grade:**	**Bus Student:** Yes No

Health Condition: **Seizure – Emergency Care**

PROCEDURE:

1. **Child should never be left alone.**
   - ●Send someone to get another adult.
   - ●Contact parent immediately.
   - ●If unable to reach parent, contact emergency person identified on student information card.
2. **Loosen all restrictive clothing around neck.**
   - ●Position student on their side, if possible, to prevent choking on saliva or vomit.
   - ●Do not insert anything in child's mouth including your fingers.
   - ●Place soft object under head.
   - ●Administer diastat if available and trained staff member is present.
3. **Observe and record the seizure.**
   - ●Length of time seizure started and when it stopped.
   - ●Any movement of body parts, separate or all extremities involved (any jerking or continuous movement).
   - ●Any breathing problems or cyanosis (appears blue).
   - ●Any incontinence or stool or urine.
4. **Call ambulance if:**
   - ●Diastat is given.
   - ●Seizure lasts longer than 5 minutes or seizure lasts less than 5 minutes and is followed by another seizure.
   - ●Parent or emergency contact can not be reached.
   - ●**Other** _____
5. **Comfort and reassure child after seizure allowing them to rest**

DOSAGE

Diastat Acudial: give: dose/route/time of day _____

Possible Side Effects: _____

Direct contact shall be made with the physician should the student receiving the medicaton develop any of the following conditions or reactions to the medication (if none, so state): _____

Medication Consent: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed.

I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication.

I further agree to hold the Word of Life Lutheran School, and the Word of Life employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school.

I agree to notify the school at the termination of this request or when any change in the above orders is necessary.

_____**Yes** _____**No** **Authorization is hereby granted to release this information to appropriate school or bus personnel and classroom teachers.**

Parent's Signature:	**Date:**
Principal's Signature:	**Date:**
Principal's Signature:	**Date:**