Primary Care Provider Authorization: Seizure Monitoring (Side One)

Student: ______________________ Date of Birth: ______________________

School: ______________________ School Year: ______________________

Type of Seizure: ☐ Grand Mal (Tonic-clonic) ☐ Petit Mal (Absence)

☐ Other (Specify): ______________________

Please specify likely characteristics.						Recommended Interventions	Comments
Duration	Specify seconds, minutes, etc.						
Aura	Is there an Aura? ☐ Yes ☐ No Conditions or behaviors that usually precede the seizures:						
Extremities		Limp	Flexed	Extended	Jerking		
	Rt. Arm	☐	☐	☐	☐		
	Lt. Arm	☐	☐	☐	☐		
	Rt. Leg	☐	☐	☐	☐		
	Lt. Leg	☐	☐	☐	☐		
Eyes	Rolled back			☐ Yes	☐ No		
	Staring Straight Ahead			☐ Yes	☐ No		
	Twitching Back and Forth			☐ Yes	☐ No		
	Looking to Right			☐ Yes	☐ No		
	Looking to Left			☐ Yes	☐ No		
Mouth	Drawn to Right			☐ Yes	☐ No		
	Drawn to Left			☐ Yes	☐ No		
	Bites Tongue/Cheek			☐ Yes	☐ No		
	Teeth Clenched			☐ Yes	☐ No		
Breathing	Noisy Breathing			☐ Yes	☐ No		
	Heavy Breathing			☐ Yes	☐ No		
	Shallow Breathing			☐ Yes	☐ No		
Other	Change in skin color			☐ Yes	☐ No		
	Drooling			☐ Yes	☐ No		
	Incontinent-Urine			☐ Yes	☐ No		
	Incontinent-Stool			☐ Yes	☐ No		
	Vomiting			☐ Yes	☐ No		

If symptoms persist after primary care provider recommendations have been followed:

* Notify parent/guardian
* Call EMS (9-911) and refer to Enrollment/Emergency Information Form

If breathing sops:

* Call EMS (9-911) and refer to Enrollment/Emergency Information Form
* CPR certified school personnel should initiate rescue breathing (and CPR if necessary)
* Notify parent/guardian

Please complete both sides of this form

Source: Jefferson County Public Schools Health Services

Primary Care Provider Authorization: Seizure Monitoring (Side Two)

Student: ______________________________ Date of Birth: ______________________________

School: ______________________________ School Year: ______________________________

Type of Seizure: ☐ Grand Mal (Tonic-clonic) ☐ Petit Mal (Absence)

☐ Other (Specify): ______________________________

In the event of generalized seizure activity, the following observations and monitoring procedures will be followed by school staff:

* Ease student to the floor (unless harnessed securely in wheelchair and breathing is not restricted).
* Remove hazards in the area, such as, sharp or hard objects, to prevent further injury.
* Loosen tight clothing at the neck.
* Turn student onto his/her side to allow saliva to drain and to keep airway open.
* Cushion the student's head with something soft.
* Monitor student while the seizure runs its course and speak to him/her in calming tones.
* Following the seizure, allow the student to rest as needed in a quiet supervised area.
* Following each occurrence, report activity to parent/guardian in writing and by telephone.

Signals of an emergency situation:

* If any seizure last longer than five (5) minutes, or
* If there is any continued, progressive respiratory distress, or
* If another seizure starts right after the first, then do the following:

Emergency action:

* Call EMS (9-911) and refer to Enrollment/Emergency Information Form.
* If breathing stops, CPR certified school personnel should initiate rescue breathing (and CPR started if needed) while awaiting medical assistance.
* Notify parent/guardian

Primary Care Provider' comments (i.e. medication, other measure- attach additional sheet if necessary):

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______________________________ ______________________________

Printed MD, ARNP, or PA Address

______________________________ ______________________________ ______________________________

Signature of MD, ARNP, or PA Telephone No. Date

*** Note to parent/guardian: Signing this form shall release the ______________Public School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.**

______________________________ ______________________________ ______________________________

Signature of Parent/Guardian Telephone No. Date

______________________________ ______________________________ ______________________________

Emergency Contact Telephone No. Relationship

Please complete both sides of this form

Source: Jefferson County Public Schools Health Services