PARENT/GUARDIAN SECTION

ADDITIONAL EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:

♦ I request this treatment plan and/or medication to be given as ordered by the licensed health professional (i.e.: doctor)

♦ I give school health services staff permission to communicate with the medical office about this treatment plan and/or medication.

♦ I understand that if ordered, diastat rectal medication or intranasal midazolam can only be given by a licensed nurse and will not be given by non-licensed school staff.

♦ Medical information may be shared with school staff working with my child and 911 staff, if they are called.

♦ All medication supplied must come in its originally provided container with instructions as noted above by the licensed health professional.

♦ A new Seizure Action Plan/Emergency Care Plan (ECP) for Seizures must be submitted every school year.

♦ I understand that if any changes are needed on the ECP, it is the parent/guardian's responsibility to contact the school nurse.

♦ It is the parent/guardian's responsibility to alert all other school programs of their child's health condition, such as clubs/sports/field trips, etc.

♦ *My signature below shows I have reviewed and agree with this Seizure Action Plan/Emergency Care Plan.*

Parent/Guardian Signature **Date**

THIS SECTION BELOW TO BE FILLED BY THE SCHOOL NURSE

School Nurse: _____ Phone: _____ Cell Phone: _____

The following school staff are trained regarding this care plan

1. _____ Date: _____ 2. _____ Date: _____

3. _____ Date: _____ 4. _____ Date: _____

Reviewed by School Nurse (Signature) Date

Health Plan and Medication (if prescribed) must accompany student on any field trip or school activity.
Keep plan readily available for *Substitutes*

ATTN Bus Drivers: To Activate Emergency Procedures-Pull Over, Call Dispatch to Call 911 if indicated on ECP