Bethel Student Health Assessment

BETHEL
Bethel Health Services
Striving Toward Student Health and Wellness

Student Name _____ School _____

Date of Birth _____ Date _____ Grade _____

SEIZURE ASSESSMENT and CARE PLAN

You have checked on school records that this student has **seizures**. It is important to have current health information & direction when she/he needs help at school. Please complete this form & return it to your child's school so that appropriate instructions may be given to school personnel. Your school nurse is available for consultation.

What type of seizure disorder does your student have? _____

How often do the seizures occur and what causes them? _____

Date of most recent seizure. _____Most recent hospitalization/emergency room visit. _____

Seizures are currently being treated by Dr. _____Phone: _____

What does the seizure usually look like and how long does it last?_____

_____

_____

Does your student need any special activity adaptations/protective equipment (e.g., helmet) at school?
_____No _____Yes (Explain)

How long after seizure before the student can return to his/her regular activities? _____

Does your child ride the school bus? ____No _____Yes Bus No. _____

ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES? ____No ___Yes (List below the medications needed)

MEDICATIONS	AMOUNT TAKEN	HOW OFTEN AND FOR WHAT SIGNS?
1. _____	_____	_____
2. _____	_____	_____

(Circle number of any of these medications to be taken at school.)

THE USUAL PROCEDURE AT SCHOOL FOR A STUDENT'S GENERALIZED SEIZURE IS TO:

1. Remove nearby hazardous objects, loosen clothing at neck and waist, protect the head from injury. Turn student on side.
2. Remove other students from the immediate environment to give privacy.
3. Time the seizure.
4. Observe student for inadequate breathing/continuous seizing. If breathing is inadequate after seizure, or if seizure lasts longer than 5 minutes, or if one seizure follows another for greater than 5 minutes, call 911.
5. Call parent/guardian
6. Allow student to rest as needed. If student is unable to return to class after 20-30 minutes, call parent.
7. Additional emergency action**:** _____

_____

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Student Name_____

Parent/Guardian Contact #1	**Emergency Contact #2**	**Emergency Contact #3**
Name _____	Name_____	Name_____
Relationship_____	Relationship_____	Relationship_____
Phone: _____	Phone: _____	Phone: _____
Work #_____	Work # _____	Work # _____

AMBULANCE PERMIT

I give consent for the school principal, school nurse, or other school personnel to use their judgment in securing further medical aid and to call an ambulance to take my (son, daughter) _____to _____Hospital in case parent/legal guardian cannot be reached.

The above information may be shared with ambulance personnel. **PERMISSION:___YES___NO**

To provide for your child's safety and educational experience the above information will be shared with school staff, included in your child's school health record and may be shared electronically.

_____ _____

Signature of Parent/Guardian Date (Valid One Year)

RETURN THIS FORM TO THE SCHOOL
(For Staff use only below this line)

	DATE	**SIGN / INITIAL**
STUDENT COMPUTER SYSTEM ENTRY	_____	_____
INFORMATION SHARED WITH STAFF	_____	_____

Additional notes:_____

_____

_____

_____

_____

_____