

Child Health Plan and Provider Orders - Seizure Disorder

Center: _____ Early Head Start Head Start ECEAP
Child's Name: _____ DOB: _____ Gender: M / F
Parent/Guardian: _____ Phone: (H) _____ (C) _____
Seizure Specialist: _____ Phone: _____ Fax: _____
Seizure Type: _____
Description: _____
Symptoms that signal or precede episodes: _____
Comments and/or special instructions: _____

Always remember to do the following:

1. Stay with child and call or send for extra help
2. Position child to avoid choking on saliva
3. Clear area around child of hazards
4. Do not put anything in child's mouth
5. Notify parents
6. Call 9-1-1 if seizure lasts more than 5 minutes or child becomes blue or stops breathing
7. Notify front office after calling 9-1-1
8. Other _____

Is medication(s) taken at home? Yes No (list): _____
Is medication(s) needed while at school? Yes No (If YES, refer to provider order's)
Is medication(s) needed during transport to/from school? Yes No

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No medication is required at school (Please sign below if you agree with this CHP).

Health Care Provider Orders for Medication at School

Important notice to provider:

Please ensure this child has a prescription on file with the pharmacy that matches the orders below. **Our policy requires Health Care Provider Orders and medication labels to match exactly.**

1) Medication Name

2) Symptoms for medication use

3) Dose

4) Frequency & Length of time between doses

5) Route

6) Possible side effects of medication

7) Special administration and/or storage instructions

8) If PRN specify Start date: _____ **AND** End date: _____

Health Care Provider's Signature

Date

Print name

Phone #

Fax #

Parent/Guardian Signature

Date

Interpreter Signature

Date

Nurse Consultant Signature

Date

ITE/Teacher Date

ITP/Assistant Date

FA/FE/FSS/HV Date

Dir/C Coor Date