Child Health Plan and Provider Orders Form - Seizure Disorder

Early Learning
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excellence & equity in education
Puget Sound Educational Service District

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 childs 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

Child's Name: ______________________________ DOB: ____________________ Gender: M / F

☐ 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

Reviewed by: Health or Nutrition Coordinator / Nurse Consultant Date

ITE/Teacher Date ITP/Assistant Date FA/FE/FSF/HV Date Dir/C Coor Date