Hustisford School District

District Office	Jr./Sr. High School	John Hustis Elementary
845 S. Lake St. · P.O. Box 326 Hustisford, WI 53034 (920) 349-8109	845 S. Lake St. · P.O. Box 326 Hustisford, WI 53034 (920) 349-3261	600 S. Hustis. St · P.O. Box 386 Hustisford, WI 53034 (920) 349-3228
Heather Cramer District Administrator	**Clint Bushey** Principal	**Heather Cramer** Principal
Jessica Holtz Director of Financial Services	**Dena Serwe** Director of Special Education/Psychologist	

Seizure Emergency Plan

TO BE COMPLETED BY THE PARENT/GUARDIAN:

STUDENT:_____Grade/Teacher:_____DOB:_____

Seizure Description

Seizure type:_____

Description of seizure: _____

Triggers: _____

Frequency of seizures: _____ per _____. Last date of seizure was: _____

Average length of seizure: _____ Usual time of day of seizure activity:_____

Name of Medication Needed at School	Dose	Route	Time of Day	Possible Side Effects
1.				
2.				

Name of EMERGENCY Medication	Dose	Route	When to be Given	Side Effects

Provider Name: _____ **Phone Number:** _____

AT THE END OF THE SCHOOL YEAR, PLEASE (check one):

Contact me to pick up remaining medication	Dispose of remaining medication	Send remaining medication home with my student

PARENT/GUARDIAN CONSENT:

- I authorize that this medication/procedure be administered at school, potentially by non-medically trained personnel.
- I will supply medication in its original, updated, properly labeled container. (Request extra bottle from pharmacist)
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information with my child's physician regarding this medication or the conditions for which it is prescribed.
- I understand the parent/guardian/responsible adult should deliver all medication to the school.
- I understand that this order/ consent is in effect for the current school year (may include summer school)..
- I consent that this treatment be provided during school hours, at after hours school sponsored events & on field trips.
- I consent to the release of the information contained in this Seizure Emergency Plan to staff members who may need to know this information to maintain my child's health and safety.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.

Parent Signature: _____ **Date:** _____

TO BE COMPLETED BY THE PROVIDER:

PHYSICIAN ORDER: The above medication/procedure is to be administered/performed in accordance with the above instructions and agreements. I agree to accept communication about student/medication/procedure and understand medication may be given by non-medically trained school personnel. My signature indicates I have fully read and understand the above information.

Physician Signature: _____ **Date:** _____

Seizure First Aid

- Stay calm and stay with the student.
- Call parent/emergency contact and possibly 911
- Don't hold the person down or try to stop their movements.
- Time the length of the seizure.
- Clear the area around the person of anything they may sustain injury from.
- Loosen ties or anything around the neck that may make breathing difficult.
- Put something flat and soft under the head, if possible.

- Turn onto one side.
- Do not force the mouth open/ place anything in the mouth.