Hustisford School District

District Office
845 S. Lake St. · P.O. Box 326
Hustisford, WI 53034
(920) 349-8109

Jr./Sr. High School
845 S. Lake St. · P.O. Box 326
Hustisford, WI 53034
(920) 349-3261

John Hustis Elementary
600 S. Hustis. St · P.O. Box 326
Hustisford, WI 53034
(920) 349-3228

Todd Bugnacki
District Administrator

Clint Bushey
Principal

Peter Moe
Principal

Corey Manlick
Director of Financial Services

Alex Pishler
Director of Special Education/Psychologist

Glen Falkenthal
Athletic Director

Seizure Care Plan and Order

Student:_____ Grade/Teacher:_____ DOB:_____

Description of seizures: _____

Triggers: _____ Frequency of seizures: ____ per _____ Last date of seizure was: _____

Student's reaction to seizure: _____Any warnings before seizure: _____

Scheduled Medication	Dose	Route	Exact time Given	Possible Side Effects

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

AT THE END OF THE SCHOOL YEAR, PLEASE (circle one): Contact me to pick up medication/Send medication home with student

- I authorize that this medication be administered at school, potentially by non-medically trained personnel.
- I will supply medication in its original, updated, properly labeled container.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize the school to communicate with the provider regarding this medication/condition 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
- I agree to hold the School District & its staff who are acting within the scope of their duties harmless in all claims arising from giving this medication
- My signature indicates that I have fully read and understand the information above.

Provider Name: _____ Phone Number: _____
Parent signature: _____ Date: _____

To be completed by the provider: *The above medication is to be administered in accordance with the noted instructions. I agree to accept communication about student/medication and understand medication may be given by non-medically trained school personnel.*

Revised 5/2025

Provider Name: _____Phone #: _____

Provider Signature: _____ Date: _____