Education at its best.
MONTELLO SCHOOL DISTRICT

Seizure Emergency Plan for School

Student:____ **Date of Birth**:__________________________

Seizure Description:

Seizure type:____

Description of seizures: ____

Possible triggers: ____

Frequency of seizures: ____________ per __________________. Last date of seizure was: __________________________

Average length of seizure activity: __________________. Usual time of day of seizure activity:________________________

Average time until student can return to regular activities: ____

Student's reaction to seizure:____

Name of Daily Medication	Dose	Route	Time of Day	Start Date	Stop Date
1.					
2.					

Name of EMERGENCY Medication	Dose	Route	When to be Given

PHYSICIAN ORDER: The above medication is to be administered 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.

Please contact me if the following symptoms occur:____

Physician Name: ______________________________ Clinic:____________________________Phone #:____________________

Physician Signature: ____ Date: ___________________________________

I hereby agree to give my permission to the school nurse to contact the child's practitioner in regard to this plan and/or medication. I further agree to hold the School District of Montello and the identified person(s) harmless in any or all claims arising from the administration of any medications given at school. I agree to notify the school in writing when any changes in the Medication Consent Form are necessary. I also consent to the release of the information contained in this Seizure Medical Management - Emergency Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

____ _______________________ ___________________

Student's Parent/Guardian Signature **Phone Number** **Date**

Updated 03/2025