PHILIPSBURG-OSCEOLA AREA SCHOOL DISTRICT
Seizure Individual Health Plan

Student Name: _____Date: _____

School: _____Duration of Plan /Order: _____Grade:____

In order to provide your child with the appropriate care, we request that this form be completed and returned to the school nurse. **If there are any changes in this information during the school year, please notify the school nurse in writing.**

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1. Type of Seizures: ___Generalized/tonic-clonic/grand mal ____Absence/petit-mal
___Simple partial/focal ____Complex partial/psychomotor

2. Known triggers or cause of seizures: _____
_____

3. Does the student experience an aura prior to a seizure? ____Yes _____No

4. **Daily Medication (s):**

5. A). Name of Medication: _____ B). Name of Medication _____
Dosage: _____ Dosage: _____
Directions: _____ Directions: _____
_____ _____

6. **Emergency Medication (s):**

A). Name of Medication: _____ B). Name of Medication: _____
Dosage: _____ Dosage: _____
Directions_____ Directions: _____
_____ _____

7. **Emergency Treatment:** _____
_____
_____

Primary Care Provider Signature: _____Date:_____

Primary Care Provider Name Printed: _____ Phone: _____

Parent/Guardian Signature: _____ Phone: _____

School Nurse Signature: _____ Phone: _____