Student Name ________________ Date Of Birth

BASIC FIRST AID: CARE AND COMFORT

First aid procedure(s): ____

____

Does student need to leave classroom after a seizure? ˆ Yes ˆ No

If yes, describe process for returning student to classroom: ______________________________

____

BASIC SEIZURE FIRST AID

- Stay calm and track time and duration of seizure
- Keep student safe
- Do not restrain or interfere with student's movements
- Do not put anything in student's mouth
- Stay with student until fully conscious

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include : Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: ____

Profession/Role: ____

Signature: ______________________________ Date: _________________________________

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.

’ This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

1. ______________________ 2. _______________________ 3.____________________________

4.______________________ 5.______________________ 6.____________________________

Other Individuals To Be Contacted Regarding Plan Of Care:

Before-School Program ˆ Yes ˆ No ____________________________

After-School Program ˆ Yes ˆ No ____________________________

School Bus Driver/Route # (If Applicable) ____