## SUMNER COUNTY SCHOOLS SEIZURE IHP/SAFETY PLAN-PRESCRIPTION MEDICATION ORDERS

Student Name:	Birth Date:
Address:	Age: Grade: Teacher:
Parent/Guardian:	
Emergency Contact/Relationship	Phone:
Neurologist/Provider:	

## SUMNER COUNTY SCHOOLS SEIZURE IHP/SAFETY PLAN-PRESCRIPTION MEDICATION ORDERS

## Medical Provider Portion

Student Name:			Date of Birth:
Rescue Medication Instru	ctions		
If seizure (cluster, # or length)			
			How much to give (dose)
How/When to give			
Care After Seizure			
What type of help is needed?(describe) _			
When is student able to resume usual act	ivity?		
Daily Medication			
Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

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