Highland Park Independent School District

Annual Health Services Prescription

Physician Authorization for Seizure Management

*This form is to be renewed at the beginning of each school year

Student name: _____ Grade: _____ DOB: _____

Parent name: _____ Phone (H): _____ (W) _____

Physician name: _____ Phone: _____ Hospital: _____

Systems	Possible Symptoms:
EYES	_____
EXTREMETIES	_____
SKIN	_____
BREATHING	_____
LOC	_____
BODY/TRUNK	_____

Potential:
Generalized: tonic-clonic Absence SimplePartial ComplexPartial Atonic Myoclonic

The severity of symptoms can quickly change. **Do not hesitate to call 9-1-1!**

TO BE COMPLETED BY THE PHYSICIAN

The parent/guardian of the above named student has notified the school that this student may experience a seizure and will require medication at school, in the event of an emergency. Please complete this form based on your records and knowledge of this student and sign in the space provided.

ACTION PLAN

Probable symptoms for this student include_____

Observe for _____minutes then:

1) Administer _____
medication/dose/route
2) Call 9-1-1
3) Contact Parents or emergency contacts.

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Physician's Signature: _____

Date :_____Physician's Name:_____

Phone:_____

Address:_____Fax_____