KNOX COUNTY SCHOOLS
ANDREW JOHNSON BUILDING

HEALTH SERVICES

INDIVIDUALIZED SEIZURE PROTOCOL FOR UNCONTROLLED SEIZURE DISORDER

NOTE: For students that require additional medical interventions.

Student's Name _____ Date _____

Date of Birth _____ School _____ Teacher _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

Diagnosis: Seizure Disorder

Type: _____

Tolerated Seizure Activity:

Time frame _____

Number of seizures _____

Criteria for notifying EMS/9ll (parents, school nurse, and Health Services office and HCP):

_____

_____

_____

Interventions:

_____

_____

Medications (medication, dose, route, and frequency):

_____

_____

If Diastat is Prescribed: Student may ride school bus ≤ 30 min without a nurse ☐ / only accompanied by a nurse ☐

Please check appropriate box if applicable.

_____ _____
Health Care Provider Signature Date

_____ _____
Phone Number Fax Number

_____
Address City, State Zip

_____ _____
Parent/Guardian Signature Date

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