

Houston Independent School District
Health and Medical Service
Emergency Plan

Student: _____
Teacher: _____
Diagnosis: _____

Parent Name(s): _____
DOB: _____
School Year: _____

Child-Specific Emergencies: Seizure

If You See This:

*Seizure of any type:

*Duration:

- *Student fails to start breathing after seizure
- *Student has no breathing/no pulse
- *Seizure last longer than 5 minutes
- *Two or more seizures in consecutive order which total 5 minutes or more
- * After Diastat seizure activity resumes

If any emergency occurs or serious injury

1. Stay with child
2. Call or designate someone to call the nurse:
State who you are:
State where you are:
State the problem:
3. The school nurse will assess the child and decide whether the emergency plan should be implemented. Always notify the building principal or administrative designee.
4. If the school nurse is unavailable, the following staff members are trained to deal with an emergency, and to initiate the emergency plan:
1. _____ 2. _____

Call Parent(s): Home: _____ Work: _____

Other Contact Person: Name _____

Relationship: _____

Telephone: _____

This is to verify that I have received a copy of the emergency plan for my child which informs me of the procedures. The child-specific emergency procedures were reviewed and explained to me. At this time all my questions have been addressed.

Parent's Signature: _____

Date: _____