Form 316-07

School ______________________

Teacher ______________________

Grade ______________________

RECURRENT SYNCOPE ("FAINTING") EPISODES

FOLLOW-UP AND PLAN

Student's Name:		Birth Date:	
Mother's Name:		Home Phone #	Work/Cell Phone #
Father's Name:		Home Phone #	Work/Cell Phone #
Emergency Contact 1	Relationship	Home Phone #	Work/Cell Phone #
Emergency Contact 2	Relationship	Home Phone #	Work/Cell Phone #
Doctor's Name:		Phone #	Clinic location

Does your child have a diagnosed condition that results in the loss of consciousness? ☐ Yes ☐ No

Is or are there doctor(s) involved in your child's care specific to syncope (fainting) episodes? ☐ Yes ☐ No

How often has/does your child experience loss of consciousness and how much time elapses on average before your child regains consciousness?
Known triggers for loss of consciousness (if any)?
When your child has lost consciousness, what care do you want your child to have until the signs and symptoms are relieved?
Please describe the follow-up school plan you want for your child following a loss of consciousness episode. NOTE: If your child does not regain consciousness after more than 2-3 minutes call 911.

______________________ (Parent/Legal Guardian Signature

______________________ (Date)