Community Education & Recreation Department
A Division of Mankato Area Public Schools

INDIVIDUAL HEALTH PLAN/EMERGENCY CARE PLAN FOR CHILD WITH SEIZURES

TO BE RENEWED EACH PROGRAM SESSION

(If you need assistance completing this form, contact the Program Coordinator)

Child's Name_____ Birth Date _____

Program Site _____ Grade_____ Session _____

According to our records, your child has a history of seizures. Completion of this form will keep your child's health record current.

1. **My child has seizures.** ____YES **Complete form, sign and date back, and return it to your child's program site.**
   ____ NO ***Parent/Guardian Signature:** _____ **Date:** _____
   (IF "NO" IS CHECKED, DO NOT FILL OUT THE REMAINDER OF THE FORM, BUT SIGN AND RETURN IT TO YOUR CHILD'S PROGRAM SITE .)
2. Check the type of seizure your child has:
   ____ Generalized tonic-clonic: Muscles become rigid with convulsive movements and impaired consciousness
   ____ Complex partial (focal impaired awareness): May consist of purposeless activity and blank stare
   ____ Simple partial (focal aware): Jerking of one limb or side of body, consciousness maintained
   ____ Absence: Brief interruption of consciousness often characterized by an appearance of daydreaming
3. **List any known seizure triggers:** _____
4. Describe any warnings and/or behavior changes before the seizure:_____
   _____
5. Any recent changes in your child's seizure patterns: ____Yes ____No
   If yes, explain: _____
6. Describe what happens during the seizure: _____
   _____
7. Describe what happens after the seizure: _____
   _____
8. How long does seizure last? _____
9. Approximate date of last seizure: _____
10. How frequent are seizures? ___daily ___weekly ___monthly ___yearly
11. Medication your child takes at home for seizures: _____
12. Will your child need any treatment or medication during CER program for seizures: ____Yes ____No
    If yes, explain: _____

If medication is needed at the program, please complete
"Consent Form For Administration of Emergency Seizure Medication"

13. Are there any special considerations or precautions regarding program activities and field trips. ____Yes ____No
    If yes, explain: _____
14. Health Care Provider Name: _____Phone #_____
    Clinic: _____ Fax #_____
15. Contact parent/guardian or alternative contact person. *(List in order of who to call first)*
    Name: _____ Relationship: _____ Daytime Phone: _____ Cell: _____
    Name: _____ Relationship: _____ Daytime Phone: _____ Cell: _____

OVER

Revised 5/2018 hh

Child Name _____

CER ACTION/EMERGENCY PLAN

If student has a seizure during the CER program, staff will do the following:

- Stay with child
- Protect child and provide privacy
- Note the time the seizure begins and ends
- Place barrier between self and body fluids
- Notify program supervisor and contact parent/guardian
- Record seizure on observation form

911 will be called if ANY of the following occur: *(Notify program supervisor and parent when 911 is called)*

- Seizure lasts more than **three** minutes (unless otherwise indicated by health care provider).
- Child has difficulty breathing
- Child aspirates
- Child becomes injured during seizure or seizure occurs in the water
- Child has repeated seizures without regaining consciousness

PARENT / GUARDIAN AUTHORIZATION

1. I understand that this plan may be shared with all CER staff working directly with my child.
2. I will contact the CER program coordinator/supervisor if a change in the current plan is indicated.
3. I authorize the CER program coordinator/designee and health care provider to exchange information related to my child's seizure plan and medication.

Parent / Guardian Signature:_____**Date**: _____

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CONSENT FORM FOR ADMINISTRATION OF EMERGENCY SEIZURE MEDICATION

TO BE RENEWED EACH PROGRAM

(If you need assistance completing this form, contact the Program Coordinator)

****Before medication can be administered by CER program personnel this form must be completed and on file****

Child's Name ____ Birth Date __________________

Program Site ______________________________ Grade ________________ Session _____________

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PHYSICIAN / LICENSED PRESCRIBER ORDER

Medication: ____ **Route:** ___________________

Dosing and Administration of Emergency Seizure Medication:

Administer _______ mg of medication after seizure of _______ minutes duration, or if _______ (indicate number) seizures occur within _______________ (indicate period of time).

Criteria for repeat dosing: ____

Other instructions:____

____

Possible side effects: ____

Emergency Seizure Medication should be administered for the following type(s) of seizure(s):

_____Generalized tonic-clonic (please describe): ____

_____Other (please describe): ____

____

PHYSICIAN/LICENSED PRESCRIBER SIGNATURE: ____________________________ DATE:______________

PRINT NAME:____ PHONE #:___________

CLINIC:____ FAX #: ______________

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PARENT/GUARDIAN AUTHORIZATION

1. I request the above medication be given to my child during CER program hours by CER program staff as ordered by the physician/licensed prescriber.
2. **I will provide this medication in the original, properly labeled pharmacy container.**
3. I authorize the CER program coordinator/designee to exchange information with my child's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, emergency plan, or side effects of this medication.
4. I authorize the CER program coordinator/designee to communicate with appropriate CER program personnel regarding this medication and emergency care plan for my child.
5. I release CER program personnel from any liability in relation to the administration of this medication during the program.
6. I have read and understand the Medication Guidelines included with this form.

Parent/Guardian Signature:____ **Date:**__________________

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Rev 05/2018 hh

GUIDELINES FOR ADMINISTRATION OF EMERGENCY SEIZURE MEDICATION

The administration of medication to students shall be done only in exceptional circumstances wherein the student's health may be jeopardized without it.

1. Administration of Emergency Seizure Medication by school personnel will only be done according to the written order of a physician/licensed prescriber and written authorization of parent/guardian.
    a. Altered forms of medication will not be accepted or administered during a CER program.
    b. Narcotics/medical cannabis will not be administered at CER program.
    c. Aspirin-containing products will not be administered at CER program.
    d. Only FDA approved treatments will be provided at CER program.

2. A new medication consent form is required when the medication dosage or instructions for administering the medication are changed.

3. New consent forms with appropriate signatures must be received each CER program session.

4. If the medication is discontinued, a physician/licensed prescriber is requested.

5. The medication must be brought to and from CER program by a parent/guardian in its original container. The following information must be on the medication container:
    a. Child's full name
    b. Name and dosage of medication
    c. Directions for administration must match the authorization form
    d. Physician/Licensed Prescriber name
    e. Date (must be current)

6. Medications are not to be carried by the child and will be kept in a locked box/cabinet designated for medication unless authorized by the Program Coordinator. **Controlled substances must never be carried by a child.**

7. Special arrangements must be made with the Program Coordinator concerning administration of medication to children through gastrostomy tubes, rectal or injectable routes.