Novi Community School District
Seizure Management Plan

Insert Photo with authorization from parent/ guardian only.

Student Name: _____ School Year: _____

School Attending: _____ Grade: _____

Teacher: _____

Reviewed by: _____ on _____
(Healthcare Provider Signature) Date

Acknowledged by: _____ Cell #1: _____
(Parent/Guardian Signature) Cell #2: _____

Acknowledged by: _____ on _____
(District Nurse Signature) Date

Signs/Symptoms of Seizure Activity may include all or some of the following:

1. Blank staring
2. Rapid eye blinking
3. Drooling
4. Clenching hands
5. Waving arms
6. Shaking/twitching of extremities
7. Nonsense speech
8. Drooping of the mouth or cheek
9. Repetitive movement of a body part
10. Uncontrolled shaking of 1 or more body parts
11. Grinding teeth
12. Student may fall down or lose consciousness

Triggers/Symptoms (Specific to Student)

1. How often does seizure activity occur?

_____

_____

2. Has hospitalization been needed in the past year for seizure activity? ☐Yes ☐No
3. Seizures are currently being treated by Dr. _____
4. What does the child's seizure look like and how long does it last?

_____

_____

5. List conditions that usually cause the seizure (e.g. noise, blinking lights)

_____

_____

6. Does the student use any special activity adaptations or protective equipment (e.g., helmet) at school? ☐Yes ☐No (Describe)

_____

_____

Are medications needed to control the seizures? ☐**No** ☐**Yes**

	Medication	**Dose/Route**
#1		
#2		

Bus Information to be completed by Parent/Guardian

Medication is to be available on the bus: Please circle YES NO

If Medication ***IS*** to be available on the bus, I _____,

parent/guardian of _____ understand that I must provide an extra medication

to be carried to and from school in the front pocket of the backpack. Transportation will be notified.

Acknowledged by District Licensed Nurse: _____Date:_____

PARENT/GUARDIAN:

I request and give permission for (name of student) _____, to receive the above medication(s)/treatment at school according to standard school district policy and for the physician or physician's staff and school district staff to share information needed to assist my child with medication needs. Schools require parent/guardian to bring medication in its original container (no exceptions will be made if not in original container). All medication must be labeled with the student's name, must be current and be approved by student's physician.

_____ _____

Parent/Guardian signature **Date**

Students with health/medical issues may be eligible for protection under Section 504, a federal disability law. Parents who wish to initiate a request for a 504 evaluation should contact the office of the student's counselor or building principal.

If a seizure last longer than 3-5 MINUTES

- Give Diastat(If ordered by physician)
- Call 911
- Notify parent/guardian that the Diastat has been administered

Total number of Diastat kits supplied to district:_____Exp date:_____

revised 12/19 ja