LOS ALAMITOS UNIFIED SCHOOL DISTRICT

Student Name_____ DOB_____

Seizure Action Plan (Page 1/3)

Student Name:_____DOB:_____

School:_____Grade/Teacher:_____

Parent/Guardian:_____Phone #_____

Printed Name of Treating Neurologist:_____

Treating Neurologist's Phone #_____Fax#_____

Seizure type:_____Length:_____Frequency:_____

Seizure Triggers or Warning signs:_____

Students reaction to seizure:_____

Significant Medical History:_____

Special Considerations (PE, recess, field trip):_____

Emergency Response and Treatment Protocol

A "Seizure Emergency" is defined as (please check all that apply):

- ☐ A Seizure (seizure type:_____) lasting >5 minutes.
- ☐ A Seizure (seizure type:_____) lasting >5 minutes.
- ☐ A cluster of >_____seizures (seizure type_____) occurring in a one hour time period.
- ☐ Other_____

Select Appropriate Response for a "Seizure Emergency" (please check all that apply)

- ☐ NO "Diastat Protocol"- Call 911 for "Seizure Emergency" as defined above.
- ☐ "Diastat Protocol"- Give Diastat _____mg Rectal Gel per rectum.
  Minimum amount of time between doses_____. Max # of doses per day_____
  Call 911 at all times when administering emergency anti-seizure medications per CA Ed Code.
- ☐ Other_____

After Diastat is given and/or if 911 is called:

> Keep child on left side in "recovery position"
> Monitor for changes in breathing pattern or color change to lips, face or other areas
> Protect head and keep airway open
> Child may vomit, have a bowel movement (stool), or urinate during or after a seizure
> Do NOT put anything inside of mouth
> Do not restrain or hold down

Neurologist's Signature:_____Date:_____

Parent Signature:_____Date:_____

LOS ALAMITOS UNIFIED SCHOOL DISTRICT

Student Name_____ DOB_____

Seizure Action Plan (Page 2 of 3)

Protocol For Observation At School After A Seizure (please check all that apply):

☐ Child should rest in Health Office for _____minutes.

☐ Child may return to class

☐ Contact parent/guardian to pick-up child from school.

Basic Seizure First Aid Care:

> Stay calm and track time
> Keep child safe and protect head
> Do not restrain
> Do not put anything in mouth
> Provide privacy
> Stay with child until fully conscious
> Loosen constrictive clothing, especially at neck and chest
> Keep airway open and watch breathing and circulation
> Turn child on side
> Record seizure on District seizure log

Parent/Guardian signature below indicates agreement to and understanding of the following:

1.Approval of the above guidelines and permission for info regarding child be available for school staff.
2 .Completion of all authorization forms and providing medication orders from physician to administer medication.
3. Responsibility to inform the Health Office of any changes in child's health, treatment plan & provide new orders.
4. Provide the necessary supplies and equipment, including a 3 day emergency supply of medication.
5. Notify the Health Office if child received emergency medication or anti-seizure medication in the last 24 hours.

I request that medication be administered to my child in accordance with our authorized health care provider's written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a credentialed School Nurse.

Parent Signature:_____Date:_____

Authorized Health Care Provider Authorization for Management of Seizures at School

My signature below provides authorization for the above written order, including administration of Diastat. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision by a credentialed School Nurse.

This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (May be faxed).

Printed Name of Neurologist_____

Neurologist Signature_____

Date_____ Phone#_____

Office Stamp

LOS ALAMITOS UNIFIED SCHOOL DISTRICT

Student Name_____ DOB_____

Seizure Action Plan (Page 3 of 3)

"VNS Seizure Treatment Protocol"

VNS (vagal nerve stimulator) Magnet Protocol for Seizures:

☐ YES – Indicated – See Below

☐ NO – Not indicated/Does not have

☐ Swipe magnet at onset of seizure

Location of VNS:

☐ Left upper quadrant of chest

☐ Other:_____

VNS Side Effects: Cough, Tickle in throat, temporary hoarseness or voice change.

☐ **Standard Protocol:** If seizure continues after 1 (One) minute of first swipe, may repeat 1(one) swipe of magnet every minute for up to 3 (three) additional swipes.

☐ **Individualized Protocol:** If seizure continues after _____minute(s) of first swipe, may repeat _____swipe(s) of magnet every minute for up to _____additional swipes.

☐ If seizure does NOT STOP with VNS magnet swipe within 5 (five) minutes, use Diastat Protocol And 911 will be called. **If no Diastat orders, call 911.**

After VNS is used:

> Child may stay in class if back to baseline neurological status.

> Parents/caregiver should receive a note/copy of the seizure record sent home with child.

☐ If child is tired, fatigued, or any other concerns, child may rest in school office for a time frame of _____minutes.

Special Considerations (PE, recess, field trip):

☐ None

☐ No contact sports

☐ No use of power tools/power equipment

☐ No activities or climbing above height of head

☐ No swimming

☐ Swimming with 1:1 adult supervision

☐ Wear "seizure" helmet at all times

☐ Other:_____

Neurologist Signature:_____Date:_____

Parent Signature:_____Date:_____

Orange County Department of Education
Instructional Services

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student:_____ Birthdate: _____
School/District: _____ Teachers Name: _____Grade/Track: _____

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION
PRESCRIPTION AND NONPRESCRIPTION

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature: _____ Date: _____

Telephone: (Work) _____ (Home) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: _____

Medication: _____ Dose: _____mg. Route: _____Time: _____

If PRN: Amount of time between doses _____ Maximum number of doses _____ per day.

Possible medication reactions: _____

Instructions for emergency care _____

Authorized Health Care Provider Signature: _____

Authorized Health Care Provider Name (print clearly):_____

Telephone _____

Date of Request: _____

Date to Discontinue Medication: _____

Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials _____

SCHOOL USE:
Reviewed by: _____ Date: _____

This request is valid for a maximum of one year.

Revised 11/15/12

Orange County Department of Education
Instructional Services

PARENT NOTIFICATION FOR THE ADMINISTRATION OF MEDICINE AT SCHOOL

***Name of Student**: _____*

TO THE PARENT/GUARDIAN:

Medical treatment is the responsibility of the parent/guardian and an authorized health care provider. An authorized health care provider is an individual who is licensed by the State of California to prescribe medication. **Medications, both prescription and over the counter**, may be given at school when it is deemed absolutely necessary by the authorized health care provider that the medication be given during school hours. **The parent/guardian is urged, with the help of your child's authorized health care provider, to work out a schedule of giving medication at home whenever possible.**

California Education Code, Section 49423 allows school personnel to assist in carrying out an authorized health care providers written orders. Designated non-medical school personnel may be assisting with your child's medication. They will be trained and supervised by credentialed school nurses. Medication will be safely stored and locked or refrigerated, if required.

Emergency medicine such as EpiPens or inhalers may be carried by the student **when recommended by a authorized health care provider and parent**. When appropriate, the school nurse will evaluate the student's ability to safely self-administer the medication based on written district guidelines. (Title 5). Back up medication should be kept at school for emergency use. Students who have a serious medical condition (diabetes, epilepsy, etc.) should have an emergency supply of their prescription medication at school with the appropriate consent forms in the event of a disaster.

IF MEDICATION IS TO BE ADMINISTERED AT SCHOOL, ALL OF THE FOLLOWING CONDITIONS MUST BE MET:

1. A written statement signed by the licensed authorized health care provider/dentist specifying the reason for the medication, the name, dosage, time, route, side effect; and specific instructions for emergency treatment must be on file at school.
2. A signed request from the parent/guardian must be on file at school.
3. Medication must be delivered to the school by the parent/guardian or other responsible adult.
4. Medication must be in your child's original, labeled pharmacy container written in English.
5. All liquid medication must be accompanied by an appropriate measuring device.
6. If pill splitting is required to obtain the correct dose of medication to be administered, only pills that are scored may be split, scored pills may be split in half only, and a commercial pill splitting device should be used for correct splitting.
7. Over the counter medication that has been prescribed by an authorized health care provider must be in its original container.
8. A separate form is required for each medication.

NOTE: Whenever there is a change in medication, dosage, time, or route the parent/guardian and authorized health care provider must complete a new form. Please discuss your authorized health care provider's instructions with your child, so that he/she is aware of the time medication is due at school**.**

This request is valid for a maximum of one year.

Revised 11/15/12

Orange County Department of Education
Instructional Services

PARENT/GUARDIAN AND AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR MEDICATION

Name of Student:_____ Birthdate: _____
School/District: _____ Teachers Name: _____Grade/Track: _____

PARENT/GUARDIAN REQUEST FOR THE ADMINISTRATION OF MEDICATION
PRESCRIPTION AND NONPRESCRIPTION

California Education Code Section, 49423 allows the school nurse or other designated non-medical school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration, and/or the prescribing authorized health care provider. I give permission for the school nurse to exchange medication-related information with the authorized health care provider. The school nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Emergency medicine such as EpiPen or inhalers may be carried by the student when recommended by an authorized health care provider and parent. Back-up medication should be kept at school for emergency use. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication.

Parent/Guardian Signature: _____ Date: _____

Telephone: (Work) _____ (Home) _____

AUTHORIZED HEALTH CARE PROVIDER REQUEST FOR ADMINISTRATION OF MEDICATION

Reason for Medication: _____

Medication: _____ Dose: _____mg. Route: _____Time: _____

If PRN: Amount of time between doses _____ Maximum number of doses _____ per day.

Possible medication reactions: _____

Instructions for emergency care _____

Authorized Health Care Provider Signature: _____

Authorized Health Care Provider Name (print clearly):_____

Telephone _____

Date of Request: _____

Date to Discontinue Medication: _____

Office Stamp

Regarding EpiPen/Inhalers: It is my professional opinion that this student should be permitted to carry/self administer this emergency Inhaler/EpiPen. This student has been instructed in, and demonstrates an understanding of proper usage.

Health Care Provider Initials _____

SCHOOL USE:
Reviewed by: _____ Date: _____

This request is valid for a maximum of one year.

Revised 11/15/12