AMERICAN LEADERSHIP ACADEMY

SEIZURE ACTION PLAN FOR SCHOOL

Student Name ______________________________D.O.B.________________ ID # ______________

School _______________________________________ Teacher_________________________________

Physician Phone: ____

EMERGENCY CONTACTS

Name	Relationship	Home #	Work #	Cell #
1.				
2.				
3.				

Type of seizure: ____

What does the seizure look like and how long does it usually last? ____________________________

____

Possible triggers that should be avoided: ____

____

Does student need any special activity adaptations/protective equipment (e.g., helmet) at school? ______

_____ No _____ Yes (explain) ____

Is student allowed to participate in physical education and other activities?

_____ No _____ Yes (explain) ____

____

ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES? _____ No _____ Yes

(List below the medications needed)

_____Vagus Nerve Stimulator implant (see VNS management order attached)

MEDICATIONS AMOUNT TAKEN HOW OFTEN AND FOR WHAT SIGNS

1. ____

2. ____

3. ____

Possible side effects that must be reported to parent or physician:

____

____

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IF GENERALIZED SEIZURE OCCURS:

1. If falling, assist student to floor, turn to side.

2. Loosen clothing at neck and waist; protect head from injury.

3. Clear away furniture and other objects from area.

4. Have another classroom adult direct students away from area.

5. **TIME THE SEIZURE.**

6. Allow seizure to run its course; **DO NOT** restrain or insert anything into student's mouth. Do not try to stop purposeless behavior.

7. During a general or grand mal seizure expect to see pale or bluish discoloration of the skin or lips. Expect to hear noisy breathing.

IF SMALLER SEIZURE OCCURS (e.g., lip smacking, behavior outburst, staring, twitching of mouth or hands)

1. Assist student to comfortable, sitting position.

2. **TIME THE SEIZURE.**

3. Stay with student, speak gently, and help student get back on task following seizure.

IF STUDENT EXHIBITS:

1. Absence of breathing or pulse.

2. Seizure of 10 minutes or greater duration.

3. Two or more consecutive (without a period of consciousness between) seizures which total 10 minutes or greater.

4. Continued unusually pale or bluish skin or lips or noisy breathing after the seizure has stopped.

INTERVENTION:

1. **Call 911**.

2. **START CPR for absent breathing or pulse.**

WHEN SEIZURE COMPLETED:

1. Reorient and assure student.

    a. Assist change into clean clothing if necessary.
    b. Allow student to sleep, as desired, after seizure.
    c. Allow student to eat, as desired, once fully alert and oriented.

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2. A student recovering from a generalized seizure may manifest abnormal behavior such as incoherent speech, extreme restlessness, and confusion. This may last from five minutes to hours.

3. Inform parent immediately of seizure via telephone conversation if:

   a. Seizure is different from usual type or frequency or has not occurred at school in past month.
   b. Seizure meets criteria for 911 emergency call.
   c. Student has not returned to "normal self" after 30-60 minutes.

4. Record seizure on Seizure Activity Log.

If you want additional care given, describe action here:

If symptoms are ____

____

Give____ (medication/dose/route)

Possible side effects ____

____

Physician Signature____ Date________________________

Print Name____ Phone________________________

I want this plan implemented for my child, _________________________________, in school. I hereby give my permission for exchange of confidential information contained in the record of my child between the nurse and physician and my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

Parent/Guardian Signature: ______________________________________Date: ________________________

Approved by School Nurse
School Nurse Signature: ____Date: ________________________

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MEDICATION PRESCRIBER/PARENT AUTHORIZATION FOR VAGUS NERVE STIMULATOR (VNS)

School Year: ________-__________

STUDENT INFORMATION
Student's Name ___________________________________ School: ___________________________________

Date of Birth: _____/_____/_____ Grade _________ Teacher _______________________________________

_____Known drug allergies/reactions If drug allergies, list: _________________Weight: ____________ lbs.

PRESCRIBER AUTHORIZATION
(To be completed by licensed healthcare provider)

START DATE: ______________________________ STOP DATE: _____________________________

Procedure: Swiping magnet over student's VNS

Reason for procedure: To shorten duration of, or stop, seizure activity.

How & frequency r/t swipe delivery: Swipe magnet over VNS for full 1-2 second time period, at onset of seizure activity.

Repeat swipe X ______________________ if seizure activity does not cease after _____________ minute(s).

If magnet is held in place over the VNS for longer than 60 seconds at one time, the generator will be turned off until the magnet is removed. Once magnet is removed, the device will resume its normal cycle.

Do you recommend the magnet be kept "on person" by the student? □ Yes □ No
If "no", storage location of magnet will be identified in student's Individualized Healthcare Plan.

Potential Contradictions/Adverse Reactions: ____

____
Printed Name of Licensed Healthcare Provider

____ ___________________ ___________________ ___________
Signature of Licensed Healthcare Provider **Date** **Phone** **Fax**

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to assist my child in the above procedure, and to delegate to trained, unlicensed school personnel, the task of assisting my child with the above prescribed procedure, in accordance with administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure. Procedure equipment or supplies must be registered with the school nurse or his/her designee.

____ ___________________ _______________________________
Signature of Parent **Date** **Phone**

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Letter to Parent Regarding Administration of Medication in School

Dear Parent:

Our school has a written policy to assure the safe administration of medication to students during the school day. If your child must have medication of any type, including over the counter drugs given during school hours, you have the following choices:

1. You may come to school and give the medication to your child at the appropriate time(s).
2. You may obtain a copy of a medication form *Request for Medication Administration in School* from the school nurse or school secretary. Take the form to your child's doctor and have him/her complete the form by listing the medication(s) needed, dosage, and number of times per day the medication is to be administered. This form must be completed by the physician for all prescription drugs and naturopathic remedies, the form must be signed by the doctor and by you, the parent or guardian. Prescription medicines must be brought to school in a pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over the counter drugs must be received in the original container, labeled with your child's name, and will be administered according to the written instructions on the label.
   (Please read initial and sign page 2, Parent/Guardian responsibilities)
3. You may discuss with your doctor an alternative schedule for administering medication (i.e. outside of school hours)
4. Self-Medication: Students requiring medication for asthma, anaphylactic reactions (or both), and diabetes may self-medicate with physician authorization, parent permission and a student agreement for self-carried medication. Students must demonstrate the necessary knowledge and developmental maturity to safely assume responsibility for and management of self-carry medications.
5. School personnel will not administer any prescription medication or naturopathic remedy to a student unless the school has received a completed *Request for Medication Administration in School* form that has been signed by both doctor and parent/guardian, and the medication has been received in an appropriately labeled container.
   If you have questions about the policy, or other issues related to the administration of medication at schools, please contact the school nurse

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Thank you for your cooperation,

____

School Nurse **Date**

____

Director **Date**

The Responsibility of the Parent or Legal Guardian

1._____ Limit the medications that must be given during the school day to those necessary in order to maintain the child at school.

2._____ Parents may choose to administer the medication at school themselves.

3._____ Medication must be delivered to the Health Office **by the parent or other responsible delegated adult**.

4._____ Provide a written request for school personnel to administer the medication. This should be in the form of a request/permission form *Request for Medication Administration in School* form. Return completed form to school.

5._____ A separate parent request/permission form must be completed for each medication given at school.

6._____The *Request for Medication Administration in School* form must be signed by a health care provider licensed to prescribe medications and include the following details:

a. Name of child and name of medication
b. Dose, route and time of medication to be given
c. Any special instructions about the child receiving the medication or about the medicine itself.
d. Start and Stop date of the medication
e. Possible side effects and/or adverse reactions to the medication
g. Name of the health care provider and how to locate or communicate with him or her if necessary

7._____ Provide the school with a new *Request for Medication Administration in School* form when there are any changes to the above details.

8._____ Provide each medication in a separate pharmacy-labeled container that includes the child's name, name of the medication, the exact dose to be given, the number of doses in the original container, the time the medication is to be given, how it is to be administered, and the expiration date of the medication.

Note: The parent should request of the pharmacist to provide two labeled containers – one for home use and one for school use – if child needs to be given medication both at home and at school.

9._____ Provide the school with new, labeled containers when dosage or medication changes are prescribed.

10._____ Over the counter medications administered at school should be provided in their original packaging labeled with the student's name.

11._____ Over the counter medications will be dispensed by health office personnel to students who have written permission from a parent or guardian to receive medication at school, as needed, for a maximum of three consecutive days. To ensure that use of this medication is not masking symptoms of a serious condition in the student, a healthcare provider's order must be submitted to the school health office for administration beyond this three-day period. OTC medications will not be dispensed during the first and last hours of the school day unless approved on a case by case basis.

12_____ For the protection of all, students are not permitted to have medications in their possession—with the exception of inhalers, EpiPens and diabetic medications and supplies, for which written permission has been given by the child's physician and parents.

13._____Retrieve all unused medications from school when medications are discontinued, and/or at end of school year (According to ALA policy) medications will be discarded 3 days from the end of the school year. Medications will not be sent home with students.

14._____ Maintain communication with staff regarding any changes to the medical treatment or child's need at school.

Parent Signature **Date**

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Request for Medication Administration in School

To be completed by physician

Name of Student: ____________________

School: ____________________

Medication: (each medication is to be listed on a separate form) ____________________

Dosage and Route: ____________________

Time(s) medication is to be given: a.m.: ____________ p.m.:____________ PRN: ____________________

Note: Medication will be given as close to prescribed time as possible but may be given up to one hour before or after prescribed time. Please advise if there is a time specific concern regarding administration.

Significant Information (include side effects, toxic reactions, reactions if omitted, etc.): ____________________

____

Contraindications to administration: ____________________

Physician *(printed)* **Name**: ____________________ Address:____________________

Physician Contact Information: Phone: ____________________ Fax:____________________

Physician's Signature: ____________________ Date: ____________________

I hereby give permission for my child (named above) to receive medication during school hours; administered by the health aide or director appointed staff. The medication will be furnished by me in the original container, labeled with the child's name and is to be given as stated above. I understand that medication will NOT be accepted if brought in by my child or is loose in a baggie, envelope or other container. I will count the medication with the staff and co-sign off on the medication. I give my consent to American Leadership Academy to contact the prescribing physician and exchange relevant medical information to clarify this medication order. I hereby release the School Board and their agents and employees from all liability that may result from my child taking this medication.

Parent/Guardian signature ____________________Date: ____________________

Please document medication count ***with parent present*** below:

Date	Medication Name	Count	Expiration Date	Parent signature	Employee initials

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Medication Administration Record (2020-2021)

A separate sheet is used for each medication or treatment

Key : A=Absent FT= Field Trip NS= No Show NM= No Medication in office RF= Refused ED= Early Dismissal

	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY
1										
2										
3										
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Additional Daily Administrations (PRN Meds only):

Date	Time	Person Administering (Name & Initials)

6913 E. Rembrandt Avenue Suite 2
Mesa, AZ 85212
Phone (480)420-2101

AMERICAN LEADERSHIP ACADEMY

SEIZURE EMERGENCY CARE PLAN FOR THE BUS DRIVER

ALA CAMPUS: ____ SCHOOL YEAR: 20____/20____

STUDENT NAME: ____

BUS# _______ ROUTE# __________ GRADE: ____________ TEACHER: __________________________

PARENT/GUARDIAN NAME: ____

PHONE #: ______________________________ CELL: ____

PRESENTING PROBLEM INFORMATION:

SEIZURE ACTIVITY

Rigid body, with jerking movements, not responding, may be drooling from the mouth.

EMERGENCY PLAN:

1. **STOP** the bus.
2. Stay calm, most seizures only last a few minutes.
3. Guide student to the floor.
4. Push objects away.
5. Note and record length of seizure.
6. **DO NOT** hold student down.
7. **DO NOT** put anything in person's mouth.
8. **DO NOT** give the person water, pills, or food until the person is fully alert.
9. **Call 911** if:
    - Seizure lasts more than 5 minutes
    - Student has repeated seizures without regaining consciousness
    - Student is injured or diabetes
    - This is student's first time having a seizure.
10. After seizure, roll student onto one side to prevent choking of vomitus or saliva.
11. Check to make sure the student is breathing. Begin CPR, as needed.
12. Report incident to school and parent.

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