Palo Alto
Unified School District

Seizure Action Plan

Emergency Anti-Seizure & Daily Seizure Medications

School Year: _____ School: _____ Grade: _____

Student Name: _____ Grade: _____ DOB: _____

List All Allergies: _____ Asthma: ☐ Yes ☐ No

*This form **must be renewed annually**, **and** if there are any changes in treatment or medication during the school year.*

Physician Authorization -- Complete information below in full. *Mark* All That Apply.

Seizure Information	
Seizure Type(s):	
Triggers, Auras, Warning Signs:	
Description:	
Length, Frequency:	

Treatment Protocol During School Hours

Does student have a Vagus Nerve Stimulator? ❒ Yes ❒ No If YES, describe magnet use:

Protocol for observing student after a seizure (including but not limited to if the student should rest in the office, return to class, and the length of time student should be under direct observation):

Basic Seizure First Aid
- Stay calm & track time
- Keep child safe. **Do not** restrain or put anything in mouth.
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:
- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response
A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check additional procedures below)
- Call 911* (911 will be called for all emergency medication administrations)
- Notify Parent and District Nurse

❒ Administer emergency medications as indicated below

❒ Notify doctor

❒ Other: _____

A seizures is generally considered an emergency when:
- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

EMERGENCY ANTI-SEIZURE MEDICATION

Medication Name: _____ Strength: _____ Required Dose: _____

Method of Administration: _____ PRN frequency: _____

When to administer the medication: _____

Potential adverse reactions and recommended mitigation actions: _____

The parent/guardian shall provide notification to the school of the details (time, amount, etc.) of any emergency anti-seizure medication administration within 4 hours of the start of a school day. If parent notifies the school of any such administration, then the above protocol should be modified as follows (describe changes, if any, to the above administration instructions in the event of a parent administration notification as described above):

Other seizure medications prescribed for the student: _____

Medication shall be administered from: _____ to _____ ☐ Remainder of school year Date emergency medication was last administered: _____

Additional Instructions: _____

Seizure Action Plan continued onto Page 2. Both Physician Authorization and Parent/Guardian Consent must be completed before medication administration can begin at school.

Health Services
25 Churchill Avenue
Palo Alto, CA 94306
Tel. 650-833-4240 | Fax 650-833-4226

Updated 5/17/2019

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DAILY SEIZURE MEDICATIONS (Complete if needed at school during school hours, overnight field trips, or emergencies)

For more than one daily seizure medication, fill out a separate Medication Authorization form.

Medication Name: _____ Strength: _____ Required Dose: _____

☐ Tablet/Capsule ☐ Liquid ☐ Injection ☐ Topical ☐ Inhaler ☐ Nebulizer ☐ Drops

Route/Location of Administration: _____ Reason for giving medication: _____

Time(s) to be given at school: _____AM/PM ☐ Daily ☐ PRN If PRN, frequency: _____

If PRN, for what symptoms: _____ Relevant side effects: _____

Medication shall be administered from: _____ to _____ or ☐ Remainder of school year

Additional Instructions: _____

Special Considerations and Precautions (regarding school activities, sports, trips, swimming, etc.)

Describe any special considerations or precautions:

My signature below provides authorization for the above orders. All procedures will be implemented in accordance with states laws and regulations. Specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse.

Physician Printed Name	Physician Signature	Date
Phone	Fax	Clinic Stamp

Parent/Guardian Consent

I request that my child be allowed to take medication at school according to instruction from the above health care provider. I authorize school personnel to assist with this medication for my child as ordered from the above health care provider. I understand trained, non-medical personnel may assist with or administer medication (Ed Code 49423 and 49480).

I give consent to communication and exchange of information between PAUSD and the health care provider listed above regarding the health care provider's written statement or any other questions about the medication or medication administration.

I understand and agree to the following responsibilities regarding medication administration:

1. This form must be renewed whenever student's prescription changes and at beginning of each school year.
2. Prescription medication must be in a container labeled by the pharmacist or health care provider and will not be expired.
3. Non-prescription medication must be in the original container with the label intact.
4. An adult must bring the medication to the school health office and pick up any outdated or unused medication.
5. Pill splitting must be done by parent/guardian prior to providing medication to school officials.
6. Parents/Guardians provide all materials or necessary equipment (e.g. measuring spoon) for medication administration.
7. Students may not carry and self-administer medication unless authorization has been given by student, parent, and health care provider.
8. Parents will notify the school and provide new consent for any changes to the above authorization.
9. Any modifications or changes to the authorizations may only be made after written notification is received from the health care provider.
10. **I understand that 911 will be called following emergency anti-seizure medication administration.** This shall not require the student be transported to an emergency room. EMS protocol may require a parent/guardian to be present to avoid transport to emergency room.
11. I understand that if emergency anti-seizure medication is administered, student will not remain at school or be transpored by bus unless authorized by the district nurse.
12. I understand that parent/guardian *must let the school know* if the emergency anti-seizure medication was given within the past 4 hours on a school day (including dosage, method of administration, and seizure characteristics).
13. I understand that emergency anti-seizure medication will not be administered on a school bus. 911 will be called for seizure emergencies.

Parent Signature	Phone	Date

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