ROCHESTER COMMUNITY SCHOOLS
SEIZURE Medical Action Plan (MAP)

Child's picture
Face only

Student's Name: _____ School: _____
Date of Birth: _____ Age: _____
Grade: _____ Teacher**:** _____

This MAP is validated with signatures and dates, by both the treating physician/licensed health care provider & parent/guardian. Orders are required for medical interventions within this treatment plan. Expiration of this plan occurs at the end of the 2022-2023 school year.

Transportation Office Use ONLY if needed
Bus #
Driver:
Route #
Medical File

CONTACT INFORMATION

Call First:	Call Second:	Call Third:
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone 1:	Phone 1:	Phone 1:
Phone 2:	Phone 2:	Phone 2:
Email:	Email:	Email:

SEIZURE HISTORY

Seizure Condition/Epilepsy Diagnosis (if applicable): _____

Date of last known seizure: _____ Length and/or frequency of typical seizure activity: _____

SEIZURE TYPE

1. ☐ Focal Onset Seizures (previously known as partial seizures)
   - ☐ Focal Aware (previously known as simple partial seizures)
   - ☐ Focal Impaired Awareness (previously known as complex partial seizures)
2. ☐ Generalized Onset Seizures ☐ Absence ☐ Tonic-Clonic ☐ Myoclonic ☐ Tonic ☐ Atonic ☐ Clonic
   - ☐ Generalized Motor Seizure (previously known as grand mal seizures)
   - ☐ Generalized Non-Motor Seizure
3. ☐ Unknown Onset Seizures

Other description of seizure activity:

Warnings signs (aura), or triggers:

Student reactions to seizures:

INSTRUCTIONS

☐ YES ☐ NO Student is on a ketogenic; parent/guardian will provide meal and/or select school lunch menu items.

☐ YES ☐ NO Past history of surgery for seizures.

☐ YES ☐ NO Notify parent immediately for all seizure activity.

☐ YES ☐ NO Student needs to leave classroom after seizure activity. If yes, describe return process:

Specific instructions for cluster seizures:

OTHER INTERVENTIONS (LUNCH, RECESS, GYM, SCHOOL SPONSORED EVENTS, ETC.)

FIRST AID FOR SEIZURE ACTIVITY

✓ Remain calm
✓ Time seizure
✓ Keep airway open, loosen clothes around neck- *monitor breathing
✓ Keep student safe from harm; protect head, turn student on their side
✓ Stay with student until they are awake and alert after seizure
✓ Re-orient student to their surroundings, post seizure activity
✓ Most seizures require first aid support but not necessarily calling 911
✓ Record seizure activity in log, notify parent/guardian, if needed
*If student stops breathing and/or loses pulses, initiate CPR

SEIZURE EMERGENCY

- Convulsion: ***longer than 5 minutes*** or per 911 instructions
- First time seizure
- Student has repeated seizures (starts another seizure right after the first)
- Student is injured or has diabetes
- Student has breathing difficulties
- Student has a seizure in water

EMERGENCY ACTION

CALL 911
Provide Seizure First Aid
Active Critical Incident Team
Call Parent/Guardian/Emergency Contact

Authorized Physician/Licensed Health Care Provider Orders & Agreement with Treatment Plan

☐ Administer: | Dose: | Route:

For seizure activity lasting longer than (in minutes):

Please only order one rescue medication for safety.

Other rescue medication instructions:

CALL 911 ANYTIME RESCUE MEDICATION HAS BEEN ADMINISTERED!

☐ YES ☐ NO Student has a vagal nerve stimulator (VNS); Magnet Instructions:

Licensed Health Care Provider's Name: _____
Hospital and/or Clinic Name: _____
Street Address: _____
Suite: _____
City/State/Zip Code: _____
Phone Number: _____
Fax Number: _____

(Provider Stamp)

HEALTH CARE PROVIDER SIGNATURE: _____ Date: _____

I, (parent/guardian), _____, request that my child, _____, receive the above described medical management at school, according to standard school policy, I authorize consent to the ordering licensed health care provider staff and school to share information, as needed, to clarify orders and to assist with my child's health care needs. I agree to have the information, in this four page plan, shared with individuals that need to know. I also, give permission to use my child's picture on this plan (if I did not supply a photo).

☐ YES ☐ NO I have read the attached information regarding section 504 eligibility.
☐ YES ☐ NO I wish to be contacted regarding a 504 evaluation.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Rochester Community Schools
Section 504 – Procedural Safeguards

The following is a brief summary description of the rights provided by Section 504 of the Rehabilitation Act of 1973 to students with disabilities, or suspected disabilities. The intent of the law is to keep you fully informed about decisions concerning your child and to inform you of your rights in the event you disagree with any decisions concerning your child. Under Section 504, you have the right to:

1. Have the District advise you of your rights under federal law; The District must provide you with written notice of your rights under Section 504. If you need further explanation or clarification of any of the rights described in this notice, please contact the Building 504 Coordinator for the school that you or your child is attending.

2. Receive written notice with respect to Section 504 identification, evaluation, educational program and/or placement of your child;

3. Have the right to agree or disagree to the implementation of the District's proposed evaluation plan for your child or to its proposed Section 504 Plan for your child.

4. Have an evaluation and placement decision for your child based upon information from a variety of sources and which is made by a team of persons knowledgeable about the student, the meaning of evaluation data, and placement options;

5. Have your child receive a free appropriate public education, which includes the right to be educated with non-disabled students to the maximum extent appropriate, if the child is Section 504 eligible;

6. Have your child take part in and receive benefits from the District without discrimination on the basis of disability;

7. Have your child educated in facilities and receive services comparable to those provided to non-disabled students;

8. Examine all relevant records of your child, including those relating to decisions about your child's Section 504 identification, evaluation, educational program, and placement; and obtain copies of those records at a reasonable cost, unless the fee would effectively deny you access to the records;

9. Receive information in your native language and primary mode of communication;

10. Have a periodic re-evaluation of your child to determine if there has been a change in educational need, including an evaluation before any significant change of placement. Generally, a re-evaluation will take place at least every three years;

11. Have your child given an equal opportunity to participate in nonacademic and extracurricular activities offered by the District;

12. Request and participate in an impartial due process hearing if you disagree with any District action with regard to the identification, evaluation, or placement of your child under Section 504. You have the right to participate personally at the hearing, have the right to be represented by counsel in that process, and to appear an adverse decision to a court of competent jurisdiction. If you wish to request an impartial due process hearing, you must submit a written Request for a Hearing to your Building 504 Coordinator;

13. File a complaint in accordance with the District's grievance procedures or with the U.S. Department of Education, Office of Civil Rights.