Glenview School District
1401 Greenwood Rd
Glenview, Illinois 60026

Seizure Packet

** New forms are required at the beginning of each school year

PLEASE NOTE:

- Your physician must complete and sign the seizure action plan
- We also require the medication administration form to be completed by your physician for any rescue or daily medications to be given during the school day.
- The parent questionaire will provide our RNs with additional information for individual health plans and staff trainings.

EPILEPSY FOUNDATION® epilepsy therapy project
STRONGER TOGETHER

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not 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 all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

A seizure 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

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

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

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

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

QUESTIONNAIRE FOR PARENT OF A STUDENT WITH SEIZURES

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

CONTACT INFORMATION:

Student's Name:_____ School Year:_____ Date of Birth:_____

School:_____ Grade:_____ Classroom:_____

Parent/Guardian Name:_____ Tel. (H):_____ (W):_____ (C):_____

Other Emergency Contact:_____ Tel. (H):_____ (W):_____ (C):_____

Child's Neurologist:_____ Tel:_____ Location:_____

Child's Primary Care Dr.:_____ Tel:_____ Location:_____

Significant medical history or conditions:

SEIZURE INFORMATION:

1. When was your child diagnosed with seizures or epilepsy?_____
2. Seizure type(s):

Seizure Type	*Length*	*Frequency*	*Description*

3. What might trigger a seizure in your child?_____
4. Are there any warnings and/or behavior changes before the seizure occurs? YES NO
   If YES, please explain:_____
5. When was your child's last seizure?_____
6. Has there been any recent change in your child's seizure patterns? YES NO
   If YES, please explain:_____
7. How does your child react after a seizure is over?_____
8. How do other illnesses affect your child's seizure control?_____

BASIC FIRST AID: Care and Comfort Measures

9. What basic first aid procedures should be taken when your child has a seizure in school?_____
   _____
   _____
   _____
   _____

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

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

10. Will your child need to leave the classroom after a seizure? YES NO
    If YES, What process would you recommend for returning your child to classroom:_____
    _____

SEIZURE EMERGENCIES

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)_____

_____

_____

_____

_____

12. Has child ever been hospitalized for continuous seizures? YES NO
    If YES, please explain: _____

_____

A Seizure is generally considered an Emergency when:

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or diabetic
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

SEIZURE MEDICATION AND TREATMENT INFORMATION

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and time of day taken	Possible side effects

14. What emergency/rescue medications needed medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to do after administration:

* *After 2nd or 3rd seizure, for cluster of seizure, etc.* ** *Orally, under tongue, rectally, etc.*

15. What medication(s) will your child need to take during school hours?_____
16. Should any of these medications be administered in a special way? YES NO
    If YES, please explain:_____
17. Should any particular reaction be watched for? YES NO
    If YES, please explain:_____
18. What should be done when your child misses a dose?_____
19. Should the school have backup medication available to give your child for missed dose? YES NO
20. Do you wish to be called before backup medication is given for a missed dose?
21. Does your child have a Vagus Nerve Stimulator? YES NO
    If YES, please describe instructions for appropriate magnet use:_____

_____

SPECIAL CONSIDERATIONS & PRECAUTIONS

22. Check all that apply and describe any considerations or precautions that should be taken

- ❑ General health_____
- ❑ Physical functioning_____
- ❑ Learning:_____
- ❑ Behavior:_____
- ❑ Mood/coping:_____
- ❑ Physical education (gym)/sports:_____
- ❑ Recess:_____
- ❑ Field trips:_____
- ❑ Bus transportation:_____

Other:_____

GENERAL COMMUNICATION ISSUES

23. What is the best way for us to communicate with you about your child's seizure(s)?_____

_____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent/Guardian Signature:_____ Date:_____ Dates Updated:_____, _____

GLENVIEW SCHOOL DISTRICT 34
1401 Greenwood Road
Glenview, Illinois 60026
www.glenview34.org

ENGLISH **AUTHORIZATION FOR ADMINISTRATION OF MEDICATION**

Parent or Guardian:
Both pages of this form must be completed prior to the administration of any medication in accordance with district policy and guidance from the Illinois State Board of Education.
All medications provided to the school must be:

- In their **original prescription container,** labeled with the name of the student, prescribing physician, name of medication, dosage, route, time to be given and name of pharmacy **OR**
- In the **original manufacturer's package**, if non-prescription medication.
- The parent/guardian or other responsible **adult should bring any medication to the school health office.**
- Medication **cannot** be expired.

Student's Name:_____ **Date of Birth:** _____

To Be Completed by the Physician:

Only medication which is prescribed by a physician and which are absolutely necessary for the critical health and well being of the student shall be given. Please indicate whether this medication must be taken during the school day. **Yes** ☐ **No** ☐

Medication: _____ **Dosage:** _____

Route:_____ **Frequency:**_____ **Scheduled** ☐ **PRN** ☐

Additional Specific Instructions: _____

Diagnosis/ Indication / Intended Effect:_____

Possible Side Effects: _____

Other Medication(s) Student is taking: _____

Duration of Order: Current School Year or other: (specify duration) _____

Emergency Medications: Epinephrine or Inhaler: (MD/PA/NP must initial below):

_____**Student may self-carry/ self-administer their emergency medication.**
I have instructed the student on the administration of this medication and find that they are able to administer this medication independently. (It is recommended that "back-up" medication be stored in the school health office).

Licensed Prescriber:

Prescriber name: _____ **Phone Number:** _____
(printed)

Signature: _____ **Date of Order:** _____

GLENVIEW SCHOOL DISTRICT 34
1401 Greenwood Road
Glenview, Illinois 60026
www.glenview34.org

Parent/ Guardian Authorization for School Medication

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event I am unable to do so or in the event of a medical emergency, I hereby authorize Glenview School District 34 and its employees and agents, on my behalf, to administer or attempt to administer to my child (or to allow my child to *self-administer* pursuant to State law, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine injectors, albuterol or opioid antagonists to my child when there is a good faith belief that my child is having an anaphylactic reaction, asthma attack or opioid overdose, whether such reactions are known to me or not. 105 ILCS 5/22-30, amended by P.A.s 99-480 and both 100-726 and 100-799 eff 1-1-19. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a certificated and registered school nurse, and I specifically consent to such practices, and.

I agree to indemnify and hold harmless District 34, members and its employees, and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.
In the event an epinephrine auto-injector is administered to my child, I acknowledge and understand that the school district personnel will call 9-1-1 to alert emergency services.

I agree to notify the school of any changes in medication for my child's condition.

I understand that I will need to pick up any unused doses of the medication at the end of the school year. Unused medications will not be sent home with my child and will be destroyed if not picked up by the last day of school.

Parent/ Guardian Signature: _____ Date: _____

Guardian Phone Number(s): _____

Parent/ Guardian Agreement Authorizing Self Carry/ Self Administration of Asthma Medication or Epinephrine Auto Injector
Before your child will be allowed to self-carry/ self-administer medication, we must ask you to sign below:

I agree with the provider statement above, and therefore authorize Glenview District 34 and its employees and agents, to allow my child to self-carry and/or self-administer the above named medication (1) at school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) during before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois Law requires the school district to inform parent(s)/ guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry and self-administration of asthma medication or epinephrine auto-injector (105 ILCS 5/22-30, amended by P.A.s 99-480 and both 100-726 and 100-799 eff. 1-1-19)

The permission for self-administration of medication is effective for the school year in which it is granted and shall be renewed each subsequent school year upon fulfillment of the requirements outlined above. We recommend that you provide an additional dose of the medication to be kept at the school in the event that your child forgets or loses his/her medication.

Your signature below indicates receipt of the above information as well as authorization for your child to carry and use his or her asthma medication or epinephrine auto-injector.

Parent/Guardian Signature: _____ Date_____

Witness:_____ Date_____

The student must complete the following section (for self-carry):
I agree to:

1. Demonstrate correct use of the inhaler or epinephrine auto-injector using a trainer to the school health office staff
2. Never share my medication with another person
3. Notify a responsible adult if there is no improvement in my breathing after using my inhaler **OR**
4. Immediately notify a responsible adult if I use my epinephrine auto-injector.

Student Signature_____ Date _____