EPILEPSY FOUNDATION®
Not another moment lost to seizures

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:

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 _____

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

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** _____

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MICHIGAN
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Seizure Observation Record

Name:				
Date & Time				
Seizure Length				
Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)				
Conscious (yes/no/altered)				
Injuries (briefly describe)				
Muscle Tone/Body Movements	Rigid/clenching			
	Limp			
	Fell down			
	Rocking			
	Wandering around			
	Whole body jerking			
Extremity Movements	(R) arm jerking			
	(L) arm jerking			
	(R) leg jerking			
	(L) leg jerking			
	Random Movement			
Color	Bluish			
	Pale			
	Flushed			
Eyes	Pupils dilated			
	Turned (R or L)			
	Rolled up			
	Staring or blinking (clarify)			
	Closed			
Mouth	Salivating			
	Chewing			
	Lip smacking			
Verbal Sounds (gagging, talking, throat clearing, etc.)				
Breathing (normal, labored, stopped, noisy, etc.)				
Incontinent (urine or feces)				
Post-Seizure Observation	Confused			
	Sleepy/tired			
	Headache			
	Speech slurring			
	Other			
Length to Orientation				
Actions Taken				
Other Comments				

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School Medication Administration Authorization Form

This order is valid only for school year (current)_____, including summer session.

School:_____

This form must be completed fully in order for school to administer the required medication.
A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of medication.

- ★ Prescription medication must be in a container labeled by the pharmacist or prescriber.
- ★ Non-prescription (over the counter) medication must be in the original container with the label intact. Students' names and date of birth must be on the medication.
- ★ Over the counter medications, except topical creams/ointments, require physician signature.
- ★ An adult must bring the medication to school. Any controlled substance must be counted with the parent and a staff member.
- ★ If a controlled substance is permitted for self carry, only the daily dose(s) needed are allowed to be carried.

Prescriber's Authorization

Name of Student:_____ Date of Birth:_____ Grade:_____

Condition for which medication is being administered:_____

Medication Name:_____ Dose(no ranges):_____ Route:_____

Time/frequency of administration:_____ If PRN(as needed), frequency:_____

If PRN(as needed), for what symptoms: _____

Special administration instructions:_____

Relevant side effects: ▫ None Expected ▫ Specify:_____

Special storage requirements: ▫ None ▫ Refrigerate ▫ Other:_____

Medication Shall be administered from:(Month/day/year):_____ to _____

Prescriber's Name/Title:_____

Telephone:_____ Fax:_____

Address:_____

Prescriber's Signature:_____

Date:_____

Parent/Guardian Authorization

I/We request school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication. I/We authorize the school personnel to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature:_____ Date:_____

Home/Cell Phone #:_____ Work Phone #:_____

Self Carry/Self Administration of Medication Authorization/Approval

Self carry/self administration of medication (including **emergency medication**) may be authorized by the prescriber and parent.

This student may carry this medication: ▫ Yes ▫ No

This student is both capable and responsible for self-administering this medication:

▫ Yes, supervised ▫ Yes, unsupervised ▫ No

Prescriber's authorization for self carry/self administration of medication: _____
Signature/Date

Parent's approval for self carry/self administration of medication:_____
Signature/Date

LHSA
A Community Action Agency

EARLY HEAD START/HEAD START
SEIZURE PARENT QUESTIONNAIRE

Child's Name _____ Teacher _____ Room _____

Dear Parent:

You have indicated on your child's enrollment forms, emergency card and/or health history that your child has a history of seizures. Please complete this form and return it to school by _____.

1. Has a doctor diagnosed your child as having a seizure disorder? Yes _____ No _____

2. Was your child's seizure caused by a high fever only? Yes _____ No _____
   If yes, how often does this happen? _____

3. Has your child had a seizure in the last 12 months? Yes _____ No _____

4. When your child has a seizure, which of the following occurs?

- ☐ Violent and generalized muscle contractions
- ☐ Loss of consciousness
- ☐ Brief muscular twitches
- ☐ Lack of attention
- ☐ Seizures on one part or side of body only
- ☐ Tongue or cheek biting
- ☐ Urinary Incontinence
- ☐ Nausea or sweating
- ☐ Dilated pupils
- ☐ Sudden tastes or smells

5. Does your child currently take medication to control seizures? Yes _____ No _____
   If yes, please list all medications. _____

6. Does this seizure disorder prevent your child from participating in school activities? Yes _____ No _____
   If yes, in what way? _____

7. Does your child need medication given to prevent seizures at school? Yes _____ No _____
   ****If your child needs medical attention or medication due to seizures while at school, you and your child's physician must complete and sign an SEIZURE ACTION PLAN.**

8. Is there anything else we need to know about your child's medical condition?
   _____

9. Parent/Guardian Signature: _____ Date: _____

Thank you for your cooperation.

_____ _____ _____
Early Head Start /Head Start Staff Phone # Date

Reviewed 1-2020

OLHSA

A Community Action Agency

OLHSA EARLY HEAD START/HEAD START
Medication Parent Consent Form

All prescription medicine must be in the original pharmacy container, clearly labeled with the child's name, physician's name, date and instructions for administering medication. To protect your child and others, please **do not leave** any medication in your child's belongings, cubby, locker or classroom. Medication must be personally delivered to a Head Start/Early Head Start staff member.

I agree to hold OLHSA Head Start/Early Head Start and its staff free from any liability in the event of allergic reaction or mishap occurring as a result of medication being administered to my child at my request and according to the instructions provided by a physician, at the center or field trip.

Child's Name: _____

Parent/Guardian Signature: _____

Date: _____