CONFIDENTIAL
Hawthorne School District

Seizure Action Plan

(includes Authorization for Seizure Medications at School)

Dear Parents/Guardians,

You and your child's healthcare provider needs to complete the form below and return it to the health office. This will allow us to provide adequate care for your child in the event of a "Seizure" at school. In the absence of this completed form, we will use the information provided on your child's enrollment form. For your child's safety, we prefer this individualized plan from you and your healthcare provider. We thank you for helping us to provide quality care for your child.

Child's Name: _____ Age: _____ Birth date: ___/___/____ Grade: _____ School Year: 20__/20__

Name of School: _____ Principal: _____ Teacher: _____ Room#: _____

Healthcare Provider completes form from this point forward.

Significant Medical History: _____

Seizure Information

Seizure Type	Length	Frequency	Description	Last Seizure Date

Seizure triggers or warning signs: _____

Student's response after seizure: _____

Seizure Response – BASIC

- Stay calm and record start of seizure
- Keep child safe but Do NOT restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Document ending time and description of seizure

Tonic-clonic seizure additional response: • Protect child's head • Turn child on side • Keep airway open • Monitor breathing

Additional Individual Student Information:

Parent requests notification after each seizure ☐ Yes ☐ No

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

If YES, describe process for returning student to classroom: _____

In case of incontinence, parent will provide extra clothing for school so student may return to class as allowed by process above. ☐ Yes ☐ No

Seizure Response – EMERGENCY

- ☐ Call 911 for paramedics
- ☐ Contact Health Clerk
- ☐ Administer emergency medications if indicated below
- ☐ Notify parents or emergency contact (as listed above)
- ☐ Notify healthcare provider listed above
- ☐ 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, has diabetes, or is pregnant
Student has a first-time seizure
Student has breathing difficulties
Student has a seizure in water

A "seizure emergency" for this student is additionally defined as: _____

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

* Emergency Medication?	*Medication Name	Dosage and Time of Day Given	Common Side Effects and Special Instructions
☐ Y or ☐ N			
☐ Y or ☐ N			

Special Considerations and Precautions (regarding school activities, sports, trips, helmet use, or bus riding after seizure, etc.)

Describe any special considerations or precautions: _____

Healthcare Provider: _____ (PRINT) Signature: _____ Date: ___/___/____

Office Address: _____ Office Telephone #: (___) _____

The following is to be completed by the PARENT OR GUARDIAN requesting medication in school:

- An **adult** must deliver the medication and this completed form to the school.
- **Renew this form annually** or earlier if healthcare provider has put a time limit on the prescription.

I request that the school nurse, health clerk or other designated personnel administer medications as directed by the healthcare provider (above). I authorize school health professional to communicate with prescribing healthcare providers and if there are inquiries regarding school Seizure management. I agree to save and hold the district, its officers, employees or agents, harmless from any/all liability, suits or claims of personal injury, bodily injury, sustained or claimed to have been sustained, as a result of administering the medication in accord with this request.

Parent's/Guardian's Signature _____ Date: ___/___/____ Home Telephone # (___) _____

Emergency Telephone Number(s) (___) _____ Name of Contact _____

(___) _____ Name of Contact _____