KLEIN ISD SEIZURE ACTION PLAN

Student's Name:_____ Birthdate: _____

Treating Physician: _____ Phone: _____

Significant medical history/diagnosis:_____

SEIZURE INFORMATION: Date of Last Seizure: _____

Seizure Type	
Average length	
Description of Seizures	
Triggers/warning signs	

BASIC FIRST AID: CARE & COMFORT:

Does student need to leave the classroom after a seizure? **YES** **NO**

Can the student independently manage or recognize their seizure activity? **YES** **NO**

If YES, for these questions provide further clarification:

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:

Should 911 be called if seizure lasts less than 5 minutes? **YES** **NO**

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

_____

✓ Seizure Emergency Protocol: *(Check all that apply)*

☐ Contact school nurse _____

☐ Call 911 for transport to _____

☐ Notify parent or emergency contact

☐ Notify treating physician

☐ Administer emergency medications as indicated below

☐ Other_____

A Seizure is considered an Emergency and 911 will be called 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 has diabetes
- ✓ Student has seizure in water
- ✓ Student has breathing difficulties

Emergency Medication Name	Dosage	Route	Repeat Dose if Expelled?

ADDITIONAL TREATMENT PROTOCOL DURING SCHOOL HOURS:

Vagus Nerve Stimulator (VNS)? YES NO

If YES, describe magnet use_____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

Physician Signature:_____ **Date:**_____

I authorize school personnel to administer the above medication and treatment during school hours. I authorize the school's registered nurse or her designee to contact the prescribing physician regarding any clarifications needed regarding the medication listed above as required to assure safe administration. I understand if the circumstances are questionable, the school employee reserves the right to deny my request while investigating.

Parent Signature:_____ **Date:**_____

Parent Emergency Contact Number: _____

Campus: *Student ID:* *May 2022*

HEALTH SERVICES

MEDICATION AUTHORIZATION FORM

Student Last Name **First name** **Birthdate** **Grade Level**

This form must be filled out completely in order for school health staff to administer medication to a student. A new medication authorization form must be completed at the beginning of each school year, for each medication, and each time there is a change in the medication's administration instructions.

In compliance with KISD board policy FFAC (local), all medications administered by KISD staff must be:

- Delivered to the clinic by a parent/guardian or his/her designee (responsible adult).
- Prescription medications must be in the original container and be properly labeled. The label must, include date prescribed, pharmacy name and address, the serial (prescription) number, student's name, prescriber name, directions for use, and any cautionary statements. It must be prescribed by a physician or dentist licensed to practice in the United States.
- Over the counter medication must be in the original manufacturer's packaging and will only be administered in accordance with manufacturer's guidelines that are age/weight appropriate for the student, unless otherwise prescribed by a physician.
- Medication not retrieved from the clinic by a parent/guardian or his/her designee (responsible adult) by the last calendar day of the current school year will be destroyed in accordance with KISD procedures.
- Over the counter medications may be administered for no longer than 2 weeks with parental approval. A physician's note will be required for any non-prescription medication needed for longer than two weeks.

Medication Name:				**Medication Unit (mg/mcg etc.):**	
Medication Dosage: *(Amount to Be Given?)*				**Special Instructions:**	
Time to Be Given:	❑ **Breakfast**	❐ **Lunch**	❐ **PRN/ As Needed**	❐ _____ **(Specific time)**	❐ **Missed AM home dose** *(if verified by parent)*
Period of Administration:		❐ **30 days**	❐ _____**days**	❐ **Duration of school year**	❐ **As needed for emergency**
Route of Administration		❐ **Oral**	❐ **Inhaled**	❐ **Nasal**	❐ _____
Reason for Medication:					
Possible Side Effects:					

I authorize school personnel to administer the above medication during school hours. I authorize the school's registered nurse or her designee to contact the prescribing physician regarding any clarifications needed regarding the medication listed above as required to assure safe administration. I understand if the circumstances are questionable, the school employee reserves the right to deny my request while investigating.

TO BE COMPLETED BY PARENT/ LEGAL GUARDIAN		**TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER**	
Parent/ Legal Guardian Printed Name:		**HCP Printed Name:**	
Phone:	**Date:**	**Phone:**	
I have completed and reviewed this form; all of the information is accurate.		**Date:**	**Fax:**
Signature:		**HCP Signature:**	

Atty approved August 2021