MINUTEMAN
ASPIRE ACCELERATE ACHIEVE

Seizure Safety Plan Acknowledgement

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

Dear Parent/Guardian,

Please review the statements below and return this signed acknowledgement with your child's Seizure IHP/Safety Plan. New seizure plans and updates may be submitted throughout the school year with medication and/or treatment plan changes. Please have any new plans and orders returned or faxed to the health office. Please note, at Minuteman, Emergency Medical Services (EMS) are activated by a call to 911. In the case of an emergency, local EMS transports to the nearest medical facility with an emergency department that is "Open" and accepting patients. A school staff member will accompany or meet your child at the hospital and stay with them until your arrival. Safety plans can be downloaded from the nurse's website at Minuteman.org.

Sincerely,
Minuteman Nurses

T: 781-918-6755 F: 781-861-3421 E: nurse@minuteman.org

As the parent/guardian of the above child, I understand/acknowledge that:

- I have read and reviewed the Seizure Safety Plan formulated by my child's physician.
- The plan will be placed on file as part of my child's school health record and the necessary information be shared with my child's teachers and staff.
- My child's seizure history and Safety Plan posted as a medical alert in the electronic student record for staff viewing.
- The school nurse may need to contact the physician completing the Seizure Safety Plan if further information or clarification is needed.
- If emergency medication(s) are ordered by my child's provider, I am responsible for providing the medication to the school health office.
- If emergency medication(s) are ordered by my child's provider but not available at school, 911 will be called and basic seizure first aid will be provided. Emergency medication(s) may not be available if the parent/guardian has not provided the medication to the health office, the student is offsite for CTE outings or field trips, or there are no trained personnel available to administer the medication.
- An action plan should be completed yearly by my child's provider. If a new plan is not received, the most recent plan on file will be followed until a new plan has been submitted.

Parent Signature: _____ **Date:** _____

Student Signature: _____ **Date:** _____

Non-Discrimination: Minuteman Regional Vocational Technical School District does not discriminate on the basis of race, color, national origin, sex, disability, religion, sexual orientation, or gender identity in its programs or activities, including its admissions and employment practices. The School District does not tolerate harassment or discrimination. An individual has been designated to coordinate compliance under Title IX and Section 504 and may be contacted through the Superintendent's Office, 758 Marrett Road, Lexington, MA 02421, (781) 861-6500.

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Seizure Safety Plan and Physician Orders

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

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

Please review, complete the plan below, and return along with the Seizure Parent Acknowledgement. This plan should be completed yearly. If a new plan is not received, the most recent plan on file will be followed until a new plan has been submitted to the health office.

Date of plan: _____

Student's physician/health care provider: _____
Address: _____
Telephone: _____ Emergency number: _____
Email address: _____

Significant Medical History: _____
_____

Seizure Information			
Seizure Type	**Length**	**Frequency**	**Description**

Seizure triggers or warning signs: _____
Student's response after a seizure: _____

Basic Seizure First Aid	**A seizure is generally considered an emergency when:**
Call 911 and school nurse	Convulsion (tonic-clonic) seizure lasts longer than 5 minutes
Stay calm and track time	Student has repeated seizures without regaining consciousness
Keep child safe; protect head	Student is injured or has diabetes
Do not restrain; turn student on side	Student has a first-time seizure
Do not put anything in mouth	Student has breathing difficulties
Stay with child until fully conscious	Student has a seizure in water
Keep airway open/watch breathing	

Basic First Aid: Care & Comfort

Please describe basic first aid procedures **specific** to this student: _____
_____

Does student need to leave the classroom after a seizure? ❒ **Yes** ❒ **No**
If yes, please describe process for student returning to classroom: _____
_____

Minuteman High School | 758 Marrett Road, Lexington, MA 02421 | T 781.861.6500 | F 781.863.1747 | TDD 781.861.2922 | minuteman.org
District Members: Acton, Arlington, Belmont, Bolton, Concord, Dover, Lancaster, Lexington, Needham, Stow

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Emergency Response	
A "seizure emergency" for this student is defined as: _____ _____ _____ _____ _____ _____ _____	**Seizure Emergency Protocol** (Check all that apply and clarify below) ❒ Call 911 for possible transport to local hospital ❒ Contact school nurse at 781-918-6755 ❒ Notify parent/guardian or emergency contact ❒ Administer emergency medication(s) as indicated below if available ❒ Notify student's doctor if parent requests ❒ Other _____

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

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

Does the 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: _____

_____

I understand that if emergency medication(s) are ordered by the physician, but are not available, 911 will be called and basic seizure first aid will be provided. Emergency medication(s) may not be available if the parent/guardian has not provided the medication to the school health office, the student is offsite for CTE outings or field trips, or there are no trained personnel available to administer the medication.

Physician Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

Student Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____

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