EPILEPSY FOUNDATION

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** _____

DPC772

SCHOOL # _____ SCHOOL YEAR _____

PATERSON PUBLIC SCHOOLS

AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS TO BE GIVEN DURING REGULAR SCHOOL HOURS

Date Given _____ Date Returned _____ Medication Started (1st dose) _____

Student's Name _____ DOB ____/____/____ Grade _____

PHYSICIAN: (medications to be given during regular school hours)

Please give the above named student the following;

Medication: _____

Dosage: _____

Time: _____

Purpose: _____

Diagnosis: _____

Medication to be taken during regular school hours:

Printed Name of Physician: _____ Address: _____

Physician's Signature: _____ Telephone: _____
Fax #: _____

****

PARENT:

I hereby give my permission for the above prescription to be given to: _____
(Print Student Name)

Parent/Guardian Signature _____ **Date** _____

APPROVED:

I hereby approve the above request for medication to be given during regular school hours.

School Doctor / Administrator _____ Date _____

****

All medications must be brought to the school by a responsible adult in the original container, appropriately labeled by the pharmacy. All medications must be counted by the school nurse, in the presence of the parent/guardian, and signed for.

All medications will be kept in a locked cabinet in the School Health Office, and administered by the School Nurse at the appropriate time.

School Nurse _____ ☎ 973-321-_____

SCHOOL # _____ SCHOOL YEAR _____

PATERSON PUBLIC SCHOOLS

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS FOR ASTHMA OR OTHER POTENTIALLY LIFE THREATENING ILLNESS

STUDENT'S NAME _____ DATE _____ GRADE _____

The above student is to take the following medication during school hours:

Medication: _____ Dosage: _____

Frequency: _____ Route: _____

Purpose: _____ Diagnosis: _____

1. It is my opinion that the medication can be self-administered during school hours by this student in school and on field trips. Instruction regarding proper care and administration procedure has been given to him/her and the parent /guardian. (A-2600) N.J.S.A. 18A:40-12.3

Family Physician's Name _____ Telephone _____

Physician's Signature _____ Date _____

****

2. I, _____ (print parent / guardian name) the parent/guardian of _____ (print student's name), give my permission for this medication to be self-administered during school hours. I am aware that the Paterson School District shall not incur any liability as a result of this self-administration, and I hold the district harmless in ANY injury or claims that arise as a result of my child's possession and/or self-administration of this medication.

Parent/Guardian's signature _____ Telephone _____

Address _____ Date _____

****

I HEREBY APPROVE THE ABOVE REQUEST FOR SELF-ADMINISTRATION OF THIS MEDICATION DURING SCHOOL HOURS.

_____ _____

SCHOOL PHYSICIAN'S SIGNATURE **DATE**

All medication must be brought to the school nurse by a responsible adult, in the original container appropriately labeled by the pharmacy.

NOTE: THIS LETTER WILL BE KEPT ON FILE IN THE NURSE'S OFFICE FOR THE REMAINDER OF THIS SCHOOL YEAR. PERMISSION FOR THE SELF-ADMINISTRATION OF MEDICATION MUST BE RENEWED ANNUALLY.

School Nurse _____ Date _____

SCHOOL # _____ SCHOOL YEAR _____

PATERSON PUBLIC SCHOOLS

AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS TO BE GIVEN DURING REGULAR SCHOOL HOURS

Date Given _____ Date Returned _____ Medication Started (1st dose) _____

Student's Name _____ DOB ____/____/____ Grade _____

PHYSICIAN: (medications to be given during regular school hours)

Please give the above named student the following;

Medication: _____

Dosage: _____

Time: _____

Purpose: _____

Diagnosis: _____

Medication to be taken during regular school hours:

Printed Name of Physician: _____ Address: _____

Physician's Signature: _____ Telephone: _____

Fax #: _____

****

PARENT:

I hereby give my permission for the above prescription to be given to: _____
(Print Student Name)

Parent/Guardian Signature _____ **Date** _____

APPROVED:

I hereby approve the above request for medication to be given during regular school hours.

School Doctor / Administrator _____ Date _____

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School Nurse _____ ☎ 973-321-

SCHOOL # _____ SCHOOL YEAR _____

PATERSON PUBLIC SCHOOLS

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS FOR ASTHMA OR OTHER POTENTIALLY LIFE THREATENING ILLNESS

STUDENT'S NAME _____ DATE _____ GRADE _____

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Frequency: _____ Route: _____

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Parent/Guardian's signature _____ Telephone _____

Address _____ Date _____

****

I HEREBY APPROVE THE ABOVE REQUEST FOR SELF-ADMINISTRATION OF THIS MEDICATION DURING SCHOOL HOURS.

_____ _____

SCHOOL PHYSICIAN'S SIGNATURE DATE

All medication must be brought to the school nurse by a responsible adult, in the original container appropriately labeled by the pharmacy.

NOTE: THIS LETTER WILL BE KEPT ON FILE IN THE NURSE'S OFFICE FOR THE REMAINDER OF THIS SCHOOL YEAR. PERMISSION FOR THE SELF-ADMINISTRATION OF MEDICATION MUST BE RENEWED ANNUALLY.

School Nurse _____ Date _____

PATERSON PUBLIC SCHOOL

ACTIVITY LIMITATION FORM

PS#: _____ **(973) 321-** _____ **DATE GIVEN:** _____ **DATE RETURNED:** _____

STUDENT: _____ **DOB:** _____ **GRADE/HR:** _____

Dear Doctor:

Our records indicate that the above named student requires an individual activity plan. Please provide a diagnosis and what accommodations, if any, are needed. Will you kindly check below the activities that the student may participate in.

PROGRAM OF FULL PARTICIPATION:

_____ **YES** _____ **NO**

Relating *to* ***DIAGNOSIS***: _____

Student **MAY PARTICIPATE FULLY** in the school program **WITHOUT RESTRICTIONS**.

PHYSICIAN PRINT/ STAMP: _____ **PHONE:** _____

PHYSICIAN SIGNATURE: _____

OR:

PROGRAM OF RESTRICTED ACTIVITY:

Start date: _____ **End Date:** _____

Relating to **DIAGNOSISI:** _____, *the following plan is indicated.*

Student **MAY PARTICIPATE** in the following activities:	**YES**	**NO**
WARM-UP EXERCISES: Stretching , walking		
LOW IMPACT AEROBICS: Jumping, hopping, jogging, dance, Zumba		
SWIMMING:		
STUNTS: Tumbling, rolling, balance, strength		
PHYSICAL FITNESS TESTING: Running, sit-ups, push-ups, pull-ups		
NON-CONTACT GAMES: Paddle ball, jump rope, badminton, tennis, bowling, other racket sports		
WEIGHT TRAINING PROGRAM: Free weights, treadmill		
TRACK AND FIELD: Sprints, intermediate & distance running, long jump, high jump, shot-put		
APPARATUS: Climbing, vaulting, support, suspension		
COMPETATTIVE GAMES: Soccer, hockey, basketball, baseball, softball, volleyball, speedball, touch football		
RECESS PLAY:		

STAIR CLIMBING (Circle) : **YES NO** * Number of flights of stairs allowed per day _____

USE OF HELMET in gym: **YES NO** in recess: **YES NO** in class: **YES NO**

OTHER PROTECTIVE *and*/or **ASSISTIVE DEVICES** ***(please specify):*** _____

OTHER RESTRICTIONS: _____

PHYSICIAN PRINT /STAMP _____ **PHONE:** _____

PHYSICIAN SIGNATURE _____ **DATE:** _____

_____ INITIAL EXAM _____ ANNUAL FOLLOW UP

Approved by School Physician: _____ **Date:** _____

PATERSON PUBLIC SCHOOLS DISTRICT
90 DELAWARE AVENUE
PATERSON, NEW JERSEY 07503

NURSING SERVICES

Date_____

Name and Address of Hospital or Health Care Provider:

_____

_____

_____

To Whom It May Concern:

This is to certify that I, _____, the
(Parent/Guardian Name)
parent / legal guardian of _____ Grade _____, do
(Student Name)
hereby give my written consent for you to release or obtain any medical records that you might have in your possession concerning _____ DOB_____.
(Student Name)

Please send records to the attention of the School Nurse at:

School Name and Address → _____

_____

_____

Signature of
Parent or Guardian: _____

Signature of
School Nurse: _____ Telephone # 973-321- _ _ _

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PATERSON PUBLIC SCHOOLS DISTRICT
90 DELAWARE AVENUE
PATERSON, NEW JERSEY 07503

DEPARTMENT OF NURSING SERVICES

Date:_____

Name and Address of School Nurse and Public School:

_____

_____

_____

To Whom It May Concern:

This is to certify that I,_____ the

Parent/Legal Guardian of _____ Grade_____, do

hereby give my written consent for you to release or obtain any medical records that you might have in your possession concerning_____ DOB_____

Please send records to the attention of the Hospital or Health Care Provider at:

Health Care Provider Address →_____

_____

_____

Signature of
Parent or Guardian:_____

Signature of
Health Care Provider:_____Telephone #:_____

Signature of
School Nurse:_____Telephone #:_____

PATERSON PUBLIC SCHOOLS DISTRICT
90 DELAWARE AVENUE
PATERSON, NEW JERSEY 07503

DEPARTMENT OF NURSING SERVICES

Parent/Guardian Permission to Release and Exchange Confidential Health Information

Student Name: _____ **DOB:** _____

Address: _____ **Student ID#**_____

To Whom It May Concern:

This is to certify that I,_____, the parent/legal guardian of _____, hereby authorize an exchange of information regarding my child, _____, to occur between the school and staff members who interact with_____.

This information may also be shared with the Intervention and Referral Service Team, Child Study Team, and /or the 504 Team if needed.

This authorization is in effect for the School Year: _____

Parent/Guardian Name (Print): _____
Parent/Guardiain Signature: _____ **Date:** _____
School Nurse: _____ Telephone Number: _____

HEALTH OFFICE

School #24/Fine and Performing Arts Program

Grade_____ Home #_____

Student's Name_____

Mother's Name_____

Father's Name_____

Address_____

City_____

Home Phone #_____

Mother's Cell #_____

Father's Cell #_____

Parent Signature _____

EMERGENCY CONTACT NUMBERS TO FOLLOW:

1. Name_____

   Relation_____

   Emergency # _____

2. Name_____

   Relation_____

   Emergency # _____

3. Name_____

   Relation_____

   Emergency # _____

INDIVIDUALIZED HEALTHCARE PLAN (IHP)
SEIZURES

STUDENT NAME:_____**DOB**_____

Student Address:
Home Phone:
Parent/Guardian:
Day/Work Phone:
Healthcare Provider:
Provider Phone:
IHP Written By:

School:
Teacher/Counselor:
Grade:
IHP Date:
IEP Date:
Review Date(s):
ICD-9 Codes:

Parental/Guardian statement: ***I/We have read this plan and agree to its implementation.***
Signature:_____**Date:**_____

Assessment Data	Nursing Diagnosis	Goals	Nursing Interventions	Expected Outcome
	Risk for injury from falling during seizure activity	The student will (if developmentally able) demonstrate safety measures, when aura presents prior to seizure, in order to prevent injury.	Reduce or remove factors that may cause or contribute to injury during a seizure. Provide student-specific information to selected school personnel for student: - Type of seizure, treatment regimen, including medication side effects - Precautions, safety issues - First aid care for immediate and recovery care - Emergency plan of care and follow-up - Evacuation plan	The student will not sustain injury during seizure while at school. The student will (if developmentally able) describe symptoms that accompany an aura. The student will wear a medical alert bracelet.