

**ROCHESTER COMMUNITY SCHOOLS  
SEIZURE Care**

Child's picture  
Face only

*This form must be completed, signed, and ATTACHED to a Seizure Medical Action Plan (MAP). Your child's neurologist will choose to either use their own MAP template, OR the Seizure MAP template listed on the RCS website.*

Student's Name: \_\_\_\_\_ School: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

This MAP is validated with signatures and dates, by both the licensed health care provider (Doctor of Osteopathic Medicine, D.O., Medical Doctor, M.D., Nurse Practitioner, N.P., or Physician Assistant, P.A.), and a parent/legal guardian. Recommended orders for medical interventions within this treatment plan, will expire at the end of the 2023-2024 school year.

**CONTACT INFORMATION**

Call First:	Call Second:	Call Third:
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone 1:	Phone 1:	Phone 1:
Phone 2:	Phone 2:	Phone 2:
Email:	Email:	Email:

**PARENT/GUARDIAN CONSENT**

I, (parent/guardian), \_\_\_\_\_, request that my child, \_\_\_\_\_, receive the attached medical management at school, according to standard school policy. I authorize consent to the ordering licensed health care provider staff and school to share information, as needed, to clarify orders and to assist with my child's health care needs. I agree to have the information, in this entire plan, shared with individuals that need to know. Also, I give permission to use my child's picture on this plan (if I did not supply a photo).

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Bus # \_\_\_\_\_ Driver: \_\_\_\_\_ Route # \_\_\_\_\_ Medical File \_\_\_\_\_  
 Transportation Office Use ONLY if needed

# SEIZURE ACTION PLAN (SAP)



Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact/Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

## Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

### Protocol for seizure during school (check all that apply)

- First aid – **Stay. Safe. Side.**
- Give rescue therapy according to SAP
- Notify parent/emergency contact
- Contact school nurse at \_\_\_\_\_
- Call 911 for transport to \_\_\_\_\_
- Other \_\_\_\_\_

### First aid for any seizure

- STAY** calm, keep calm, **begin timing seizure**
- Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- STAY** until recovered from seizure
- Swipe magnet for VNS
- Write down what happens \_\_\_\_\_
- Other \_\_\_\_\_

### When to call 911

- Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- Difficulty breathing after seizure
- Serious injury occurs or suspected, seizure in water

### When to call your provider first

- Change in seizure type, number or pattern
- Person does not return to usual behavior (i.e., confused for a long period)
- First time seizure that stops on its' own
- Other medical problems or pregnancy need to be checked

### When rescue therapy may be needed:

#### WHEN AND WHAT TO DO

If seizure (cluster, # or length) \_\_\_\_\_  
Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_  
How to give \_\_\_\_\_

If seizure (cluster, # or length) \_\_\_\_\_  
Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_  
How to give \_\_\_\_\_

If seizure (cluster, # or length) \_\_\_\_\_  
Name of Med/Rx \_\_\_\_\_ How much to give (dose) \_\_\_\_\_  
How to give \_\_\_\_\_

## Care after seizure

What type of help is needed? (describe) \_\_\_\_\_

When is student able to resume usual activity? \_\_\_\_\_

## Special instructions

First Responders: \_\_\_\_\_

Emergency Department: \_\_\_\_\_

## Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

## Other information

Triggers: \_\_\_\_\_

Important Medical History \_\_\_\_\_

Allergies \_\_\_\_\_

Epilepsy Surgery (type, date, side effects) \_\_\_\_\_

Device:  VNS  RNS  DBS Date Implanted \_\_\_\_\_

Diet Therapy  Ketogenic  Low Glycemic  Modified Atkins  Other (describe) \_\_\_\_\_

Special Instructions: \_\_\_\_\_

## Health care contacts

Epilepsy Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

My signature \_\_\_\_\_ Date \_\_\_\_\_

Provider signature \_\_\_\_\_ Date \_\_\_\_\_



**ROCHESTER COMMUNITY SCHOOLS**

Authorization for Medication Administration

School Year: 2023-2024

Student name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Grade: \_\_\_\_\_

**To be completed by the Physician or Authorized Prescriber: ONE MEDICATION PER FORM**

(Michigan law and district policy require written authorization for a student to take any medication during the school day).

Name of medication: \_\_\_\_\_ Reason for medication: \_\_\_\_\_

Dose (please do not give a range): \_\_\_\_\_  MG  ML  MCG  Units  Other: \_\_\_\_\_

Route:  Oral  Injection  Inhalation  Intra-nasal  Other: \_\_\_\_\_

Frequency:  Daily  Other (please be specific): \_\_\_\_\_

Routine time(s) to be given:  \_\_\_\_\_ AM  \_\_\_\_\_ PM  Other: \_\_\_\_\_

As needed (PRN), (*absent clear and objective criteria, medication cannot be administered during the school day*):

Special instructions or side effects: \_\_\_\_\_

Student is both capable and responsible for self-administering this medication (*applicable ONLY to high school students*):

No  Yes- supervised  Yes- unsupervised

Student may self-carry an inhaler (*applicable to all students*).  Yes  No  Not applicable

Student may self-carry an Epi-Pen (*applicable to all students*).  Yes  No  Not applicable

START:  Date from received Other date: \_\_\_\_\_  For episodic/emergency events only

STOP:  End of school year Other date/duration: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Clinic/Hospital Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date: \_\_\_\_\_ Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

**To be completed by Parent/Legal Guardian**

I understand and agree that all medication must be in the original container, clearly marked with the student's name, name of medication, and prescribed dosage. I acknowledge that I am required to immediately inform the district of any changes to the healthcare provider's administration instructions. Authorization also includes permission for school personnel and health care provider to contact each other, if needed. I request and authorize the following (*check appropriate direction below*):

School personnel store and administer medication to the above-named student, as authorized by prescriber.

School personnel store medication only. The above-named student shall be responsible for self-administering medication.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## ROCHESTER COMMUNITY SCHOOLS

### Medication Procedures (as per standard school policy)

- Medication authorization is for the current school year only and will expire at the end of the school year.
- Only one medication per form. A separate form is required for each medication, each school year.
- Written authorization with medication order completed, signed by the student's authorized healthcare provider and a parent/guardian, is required before any medication can be given at school. Medications include prescription, and non-prescription over-the-counter, including but not limited to: homeopathic, herbal, vitamin, mineral preparation, topical creams or ointments, eye or ear drops, transdermal patches, nasal sprays or mists.
- Medication administration during school hours will be permitted only when failure to do so will jeopardize the health of a student, or the student would not be able to attend school if the medication or treatment were not available during school hours. Parents/legal guardians are urged to administer medication at home and on a schedule, other than school hours, if possible.
- Medication must be brought to school by the student's parent/legal guardian, unless the student has been authorized to self-carry the medication. The district reserves the right to determine that a student may not self-carry for any reason.
- Medication must be administered by an adult in the presence of a second adult, unless the medication is administered by a licensed registered professional nurse or there is an emergency that threatens the student's life or health.
- Parent/legal guardian will ensure that an adequate amount of medication is on hand at the school for the duration of the student's need to take medication, and responsible for checking the need for refills, including expired medications, and replenishing medication to the school in a timely manner.
- All medication must be in a container as prepared by a pharmacy, authorized healthcare provider, or pharmaceutical company, and clearly marked with the student's name, the name of the medication, the prescribed dose, time and frequency of medication administration and special instructions, if any.
- All controlled substance medication will be counted and recorded in the presence of the parent/legal guardian when brought to school.
- Changes in dosage, frequency, or time of administration cannot be made without written instruction from an authorized healthcare provider.
- Designated staff will be responsible for storage, administering medication and notifying parent/legal guardian, in the event that a student refuses medication.
- Medication left over at the end of the school year, or after a student has left the district shall be picked up by the parent/legal guardian. Any medication not retrieved by the parent/legal guardian will be properly disposed of within 7 days of the last student day of school and documented by the individual who is responsible for administering medication.