Each student with Epilepsy is required to have a Seizure Action Plan (SAP) on file at the beginning of the school year or upon returning to school after an initial diagnosis. The Health Care Provider may prefer to use their own SAP, or you may submit the SAP provided here. Whichever SAP you provide, please include the Parent Questionnaire. Additionally, an Authorization to Administer Medication Form is required for each medication to be given at school. This includes any over-the-counter as well as any daily prescription medications that you wish to keep at school to be given in the event of a missed dose usually given at school. Lastly, a Consent for Release of Medical Information Form is included and only needs to be completed and signed by a parent/guardian if you prefer for the nurse to fax all the necessary forms to the physician to be completed. If you opt to have the nurse fax the forms to the doctor on your behalf, please sign all required forms and send them to the school nurse.

Additional tools & resources from the Epilepsy Foundation can be found here:
https://www.epilepsy.com/tools-resources

DUNELAND
HEALTH SERVICES

AUTHORIZATION TO ADMINISTER PRESCRIPTION & NON-PRESCRIPTION MEDICATION

NAME _____ **SCHOOL** _____ **GRADE** _____

☐ SCHEDULED

MEDICATION _____ **DOSAGE** _____ ☐ AS NEEDED **TIME** _____

REASON FOR GIVING _____ **START DATE** _____ **END DATE** _____

THIS SECTION REQUIRED FOR PRESCRIPTION MEDICATIONS ONLY

_____
Physician Signature
(Or copy of current label)

I have prescribed the medication(s) below and authorize the nurse or the principal designee to administer the medication(s) as follows with time adjustments to accommodate lunches, late arrival, early dismissal, etc.

This patient has demonstrated they are capable of following the instructions regarding safe and appropriate use of this emergency medication and should be permitted to carry this medication provided permission has been granted per school guidelines *(Controlled substances not permitted to be carried by student).*

_____
Physician Signature
(Must be signed for student to self-carry)

_____ _____ _____
Healthcare Practitioner Name (Printed) **Phone Number** **Date**

PARENT AGREEMENT/AUTHORIZATION:

- The nurse and/or the principal designee has my permission to administer this medication to my child as prescribed and/or directed
- The parent/guardian is responsible for supplying this medication to the school in an original labeled container (this includes pharmacy labels for prescription medications)
- The parent/guardian is responsible for replacing medications on/before their expiration dates
- Changes to the medication dosage and/or administration frequency require a new Authorization to Administer Medication Form be completed along with physician signature or updated pharmacy label for prescription medications
- Authorization to Administer Medication Form must be renewed each school year
- Student's may not be in possession of or transport medications without a current Authorization to Administer form on file
- Medications not picked up at the end of the school year will be disposed of properly
- Parent/Guardian is responsible for notifying the nurse or principal designee if the medication is not to be given for any reason (late arrival, early dismissal, discontinuation, etc.)

_____ _____ _____
Parent/Guardian Printed Name **Parent/Guardian Signature** **Date**

DUNELAND
HEALTH SERVICES

Student Name: _____ Date: _____ Class: _____

Dear Parents/Guardian,

In preparation for the end of the school year, we must coordinate the return of any remaining medication your child has at school. Per Duneland School Corporation policy, medication that is possessed by a school for administration during school hours may be released to the student's parent/guardian or to an individual who is 18 years of age or older and who has been designated, in writing, by the student's parent/guardian to receive the medication. A school may send medication not classified as a controlled substance that is possessed by a school for administration during school hours with a student only if the student's parent/guardian provides written permission for the student to receive the medication. The completion of this form and submission to the school nurse serves as an official written permission.

Medication Returned:	QTY	NAME OF MEDICATION
	_____	_____
	_____	_____
	_____	_____

_____ I will pick up my child's medication by _____ and understand that any medications not picked up on or before Thursday, May 30, 2024 or medications not being forwarded to summer school will be discarded.

_____ Please send my child's medication home no sooner than_____ (Controlled substances cannot be sent home with student)

_____ Please forward my child's medication to _____school for 2024 summer school

_____ I authorize _____ who is at least 18 years of age to pick up my child's medication on or before Thursday, May 30, 2024

_____

Parent/Guardian Name (Printed)

_____ _____

Parent/Guardian Signature Date

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EPILEPSY FOUNDATION

Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Contact Information

Student's Name	School Year	Date of Birth	
School	Grade	Classroom	
Parent/Guardian	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	Location	
Significant Medical History or Conditions			

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? _____
2. Seizure type(s)

Seizure Type	Length	Frequency	Description

3. What might trigger a seizure in your child? _____
4. Are there any warnings and/or behavior changes before the seizure occurs? ❒ YES ❒ NO
   If YES, please explain: _____
5. When was your child's last seizure? _____
6. Has there been any recent change in your child's seizure patterns? ❒ YES ❒ NO
   If YES, please explain: _____
7. How does your child react after a seizure is over? _____
8. How do other illnesses affect your child's seizure control? _____

Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? ❒ YES ❒ NO
    If YES, what process would you recommend for returning your child 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

Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? ❒ YES ❒ NO
    If YES, please explain:

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

Seizure Medication and Treatment Information

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and Time of Day Taken	Possible Side Effects

14. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to Do After Administration

** After 2nd or 3rd seizure, for cluster of seizure, etc.* *** Orally, under tongue, rectally, etc.*

15. What medication(s) will your child need to take during school hours? _____
16. Should any of these medications be administered in a special way? ❒ YES ❒ NO
    If YES, please explain: _____
17. Should any particular reaction be watched for? ❒ YES ❒ NO
    If YES, please explain: _____
18. What should be done when your child misses a dose? _____
19. Should the school have backup medication available to give your child for missed dose? ❒ YES ❒ NO
20. Do you wish to be called before backup medication is given for a missed dose? ❒ YES ❒ NO
21. Does your child have a Vagus Nerve Stimulator? ❒ YES ❒ NO
    If YES, please describe instructions for appropriate magnet use:

Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

❒ General health _____ ❒ Physical education (gym/sports) _____
❒ Physical functioning _____ ❒ Recess _____
❒ Learning _____ ❒ Field trips _____
❒ Behavior _____ ❒ Bus transportation _____
❒ Mood/coping _____ ❒ Other _____

General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? _____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ❒ YES ❒ NO

Dates _____
Updated _____

Parent/Guardian Signature _____ **Date** _____

SEIZURE ACTION PLAN (SAP)

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact 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 person 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 _____

Epilepsy.com

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EPILEPSY FOUNDATION | END EPILEPSY

Seizure Observation Record

Student Name:				
Date & Time				
Seizure Length				
Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)				
Conscious (yes/no/altered)				
Injuries (briefly describe)				
Muscle Tone/Body Movements	Rigid/clenching			
	Limp			
	Fell down			
	Rocking			
	Wandering around			
	Whole body jerking			
Extremity Movements	(R) arm jerking			
	(L) arm jerking			
	(R) leg jerking			
	(L) leg jerking			
	Random Movement			
Color	Bluish			
	Pale			
	Flushed			
Eyes	Pupils dilated			
	Turned (R or L)			
	Rolled up			
	Staring or blinking (clarify)			
	Closed			
Mouth	Salivating			
	Chewing			
	Lip smacking			
Verbal Sounds (gagging, talking, throat clearing, etc.)				
Breathing (normal, labored, stopped, noisy, etc.)				
Incontinent (urine or feces)				
Post-Seizure Observation	Confused			
	Sleepy/tired			
	Headache			
	Speech slurring			
	Other			
Length to Orientation				
Parents Notified? (time of call)				
EMS Called? (call time & arrival time)				
Observer's Name				

Please put additional notes on back as necessary.

DUNELAND SCHOOL CORPORATION
601 W Morgan Avenue; Chesterton, In 46304
219-983-3600 fax 219-983-3614

Student/ Patient Name:_____ Date of Birth:_____

☐ Send from: ☐ Send to:	☐ Send from: ☐ Send to:
Duneland School Corporation **(and its affiliates, employees and agents)** **601 W Morgan Avenue Chesterton, In 46304** **219-983-3600 fax 219-983-3614** Attn: (name and title): _____	Agency: _____ (and its affiliates, employees and agents) Address: _____ City/State: _____ Phone number: _____ Fax number: _____ Attn: (name and title) _____

A. Information to be disclosed:

Typical **School** Information)

☐ Transcripts, report cards, attendance reports
☐ School Health Records
☐ RTI Data/General Education Referral
☐ Specialized/Diagnostic Evaluation
☐ Special Education Records/Psychological Evaluation
☐ Discipline and Behavior Records
☐ Other _____
_____

(Specific Mental Health/Health Agency Information to be released)

☐ Entire medical record including all of below:
☐ Medical History/Hospitalization
☐ Summary of Psychiatric Treatment
☐ Medication History
☐ Psychiatric Evaluation Results
☐ Mental Disorder/Diagnosis
☐ Most Recent Contact Date
☐ Drug and Alcohol Information
☐ Treatment Plan
☐ Clinician's Office Notes
☐ Patient Histories
☐ Test Results
☐ Records sent to you by other health care providers

By signing here, _____, I give specific authorization to disclose the following:

☐ HIV test results ☐ Drug and alcohol abuse treatment records ☐ Psychotherapy notes
☐ Documentation of AIDS diagnosis ☐ Psychiatric/Mental health treatment records

B. Purpose of Disclosure:

☐ At the request of the individual or ☐ Other:_____
_____

C. Authorization to Discuss Health Information

☐ By initialing here _____ (Initial) I authorize _____ (Name of individual health care provider) to discuss my health information with the School listed here:

_____
(Name of individual or school entity)

D. Authorization Statements:

- I understand that I am not required to sign this authorization but I further understand that failure to grant authorization for the requested information may limit the school's ability to determine eligibility for services and/or develop an appropriate education plan for the student.
- I understand that the records for which I am authorizing release, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become educational records protected by the Family Educational Rights and Privacy Act. As educational records, they may be subject to re-disclosure.
- I understand that this authorization is valid from the date of my/my representative's signature below and shall expire one year from that date, unless I revoke this authorization in writing.
- I understand that I may withdraw or revoke my permission at any time by writing to the Superintendent of Duneland School Corporation, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I further understand that I am entitled to receive a copy of this authorization, if requested, and that a photocopy of this authorization is as valid as the original.
- I release the individuals and/or organization named in this authorization from legal responsibility or liability for the disclosure of the records authorized on this form.

_____ _____
Signature of Adult Consenting to Release (Either Employee or Parent) Date

_____ _____
Student Signature (if aged 12 or older) Date