SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

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 _____

EPILEPSY FOUNDATION | END EPILEPSY

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 DIAGNOSIS: _____, **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: springs, intermediate & distance running, long jump, high jump, shot-put		
APPARATUS: climbing, vaulting, support, suspension		
COMPETITIVE 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
New Roberto Clemente/Newcomers @ NRC
482-506 Market Street, Paterson, NJ 07501
School Health Office
Telephone: 973-321-0249
Fax: 973-321-0247

Grade _____ Homeroom # _____

Student Name: _____

Mother's Name: _____

Father's Name: _____

Address: _____

City: _____

Home Phone #: _____

Mother Cell # _____

Father Cell #: _____

Parent Signature: _____

Emergency contact numbers to follow:

1. Name: _____
   Relation: _____
   Emergency #: _____

2. Name: _____
   Relation: _____
   Emergency #: _____

3. Name: _____
   Relation: _____
   Emergency #: _____

PATERSON PUBLIC SCHOOLS

Department of Nursing Services
90 Delaware Avenue, Paterson NJ 07503
Office: (973) 321-0722 Fax: (973) 321-0485

Date: _____

Name and Address of Hospital or Health Care Provider:

_____

_____

_____

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 School Nurse at:

School Name and Address _____

_____

_____

Signature of Parent or Guardian: _____

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

PATERSON PUBLIC SCHOOLS

Department of Nursing Services
90 Delaware Avenue, Paterson NJ 07503
Office: (973) 321-0722 Fax: (973) 321-0485

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 Healthcare Provider: _____ Telephone: _____

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