

**OLDHAM COUNTY BOARD OF EDUCATION  
ADMINISTRATIVE REGULATION FORM**

**SEIZURE ACTION PLAN**

**9009.05F**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

School: \_\_\_\_\_ Grade/Year: \_\_\_\_\_

Treating Physician: \_\_\_\_\_ Office Number: \_\_\_\_\_

Type/s of Seizure: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

**SEIZURE INFORMATION:**

DATE OF LAST KNOWN SEIZURE	SEIZURE TYPE	DESCRIPTION

Seizure triggers or warning signs:

\_\_\_\_\_

Student's likely characteristics during and reaction after seizure:

\_\_\_\_\_

**EMERGENCY RESPONSE:**

**SEIZURE EMERGENCY PROTOCOL (check all that apply):**

- Time seizure
- Contact School Nurse/office at: \_\_\_\_\_
- Administer emergency medication if indicated below
- Notify parent or emergency contact
- Other: \_\_\_\_\_

**CALL 911 if:**

- Emergency medication is administered (*911 is required if emergency med given*)
- Respiratory distress
- Student has repetitive seizures
- Other: \_\_\_\_\_

**Basic Seizure First Aid:**

- Stay calm and track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child
- Record seizure in log
- Protect head (for grand mal)
- Keep airway open
- Turn on side

A seizure is generally considered an **Emergency** when:

- A convulsive seizure is **longer than 5 min**
- Repeated seizures without regaining consciousness
- First time seizure
- Student injured or diabetic
- Breathing difficulties
- Seizure in water

**TREATMENT PROTOCOL DURING SCHOOL HOURS:**

Will student require Emergency Medication at school?  YES  NO

Does student take daily seizure medication at home?  
 YES  NO If yes, please list: \_\_\_\_\_

Does student have a Vagus Nerve Stimulator?  
 YES  NO If yes, describe use of magnet: \_\_\_\_\_

OLDHAM COUNTY BOARD OF EDUCATION  
ADMINISTRATIVE REGULATION FORM

SEIZURE ACTION PLAN

9009.05F

**PRESCRIBED EMERGENCY MEDICATION FOR SCHOOL:**

*(Please select and complete directions for use)*

**DIASTAT Rectal Gel** For school staff:  Green ready band visible and locked with correct dose

Dose: \_\_\_\_\_ MG PER RECTUM to be administered \_\_\_\_\_ minutes after onset of seizure

Other directions: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

**KLONOPIN Buccal Tab**

Dose: \_\_\_\_\_ MG to be administered between cheek and gum \_\_\_\_\_ minutes after onset of seizure.

Other directions: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

**NAYZILAM (Midazolam) Nasal Spray**

Dose: \_\_\_\_\_ MG single spray into one nostril \_\_\_\_\_ minutes after onset of seizure.

Other directions: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

**VALTOCO (Diazepam) Nasal Spray**

Dose: \_\_\_\_\_ MG single spray into one nostril \_\_\_\_\_ minutes after onset of seizure.

Other directions: \_\_\_\_\_ Expires: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

**This medication can be kept:**  On Student  Classroom  Office/Health Room

**This medication is required to be available on the bus:**  \*YES\* *See transportation directives on page 2*  NO

**PHYSICIAN SIGNATURE AND CONTACT INFORMATION:**

Myself or a licensed member of my staff has witnessed the student demonstrate the disease management skills to determine competency. The information was not determined solely by parent report. Changes or updates to this health care plan will be made available when requested by licensed medical personnel of the Oldham County Board of Education.

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Physician Printed Name*

\_\_\_\_\_  
*Telephone*

\_\_\_\_\_  
*Fax*

**TRANSPORTATION DIRECTIVES:**

In the event of a seizure during transport, student will remain in seat with breathing and airway status monitored by bus staff. **If respiratory distress is noted, or seizure does not subside, 911 will be called.**

**Is Emergency Medication to Be Administered on The School Bus Route to And from School?**

YES\*  NO

*\*If an emergency medication is prescribed by the physician to be administered during bus transportation to/from school, two trained staff members are required and available only on a "specially equipped" bus.*

**Is Emergency Medication to Be Administered During Bus Transportation on Field Trip Events?**

YES\*  NO

*\*For regular education students with a prescribed emergency medication: Transportation will be provided on a 'specially equipped' bus for field trip events unless parent and physician sign the **Waiver of Special Transportation on the following page:***

**OLDHAM COUNTY BOARD OF EDUCATION  
ADMINISTRATIVE REGULATION FORM**

**SEIZURE ACTION PLAN**

**9009.05F**

**PARENT LIABILITY WAIVER AND RELEASE OF INFORMATION**

I understand that the employees of the Oldham County Board of Education to whom health services are delegated may not be licensed healthcare professionals. In the case of an emergency that requires immediate intervention at school or at a school event, employees who have been delegated health services will undertake to do their best to comply with the recommended protocols developed by the student's physician, in accordance with training conducted by a Registered Nurse. I hereby consent to the interventions of the employee in accordance with the instructions above/attached. Additionally, in accordance with KRS 156.502 and 158.383(4), I agree to hold staff members harmless for any injuries resulting from the emergency care, medication administration, or reaction to any medication administration unless the injury was caused by the Board of Education employee's negligence.

I further hereby give my consent for medical records and reports to be shared with the Oldham County Board of Education and for my child's physician, referenced above, to discuss my child's medical condition with designated District personnel to assist them in planning for my child's care while at school or at school events.

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

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

\_\_\_\_\_  
*Physician Signature:*

\_\_\_\_\_  
*Date:*

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

**\*WAIVER OF SPECIALLY-EQUIPPED TRANSPORTATION AND RELEASE OF LIABILITY\***

I hereby request waiver of special transportation for field trips during the current school year. I understand that my child is entitled to special transportation due to my child's medical condition and that special transportation has been offered by the district at no additional cost to me.

I understand that declining special transportation will result in my child being transported by regular school bus unless the students are travelling by charter bus. The space limitations and configuration of bus seats on a regular bus pose additional safety risks to my child and especially in the event that Diastat is the prescribed medication to be administered. I have evaluated the risks to my child and determined that it is in my child's best interest to be transported by regular bus.

To the extent allowable by law I, for myself, my spouse, my child and our heirs, hereby indemnify and hold harmless my child's school and Oldham County Board of Education, their members, officers, employees, agents, insurers, successors and assigns from any liability, damages, or injury sustained by my child as a result of the administration of Diastat or other Emergency Medication on a regular school bus while traveling to and from school field trips.

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

I have reviewed the child's medical condition and the risks associated with traveling on a regular school bus and I agree with the parent's request to waive specially-equipped transportation during school field trips.

\_\_\_\_\_  
*Physician Signature:*

\_\_\_\_\_  
*Date:*

**FOR OFFICE USE ONLY:**

Medication brought in by: \_\_\_\_\_ Date: \_\_\_\_\_

Medication picked up by: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by OCBE RN: \_\_\_\_\_ Date: \_\_\_\_\_