Canon-McMillan School District

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:_____ DOB: _____HR: _____

Parent/Guardian:_____ Phone: _____Cell:_____

Treating Physician:_____

Significant medical history:_____

SEIZURE INFORMATION:

Seizure Type	*Description*

Seizure triggers or warning signs:_____

_____

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as:

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 (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

Seizure Emergency Protocol: *(Check all that apply and clarify below)*
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Call 911 for transport to _____
- ☐ Other_____

EMERGENCY/RESCUE MEDICATION(S): (additional form provided): _____

A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO
If YES, additional form provided

TREATMENT PROTOCOL: (daily medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

Parent Signature:_____ **Date:**_____

CANON-McMILLAN SCHOOL DISTRICT
200 Big Mac Boulevard
Canonsburg, PA 15317

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

(Prescription and Over the Counter)

DATE: _____ GRADE: _____

_____ must receive the following medication
(Full Name of Pupil)
during school hours in order to maintain sufficient health to participate in the school program. All medication must be in the original manufacturer's container or the pharmacy labeled bottle.

Name of Medication: _____

Prescribed Dosage: _____

Time Schedule: _____

Length of Time (days/weeks): _____

Reason for Administration: _____

Possible Side Effects: _____

Regarding asthma inhalers, the child (check only one) _____ is _____ is not able to self-administer the medication. If the student can self-administer, s/he has permission to carry the inhaler.

Regarding epi-pens, the child (check only one) _____ is _____is not permitted to carry the epi-pen with them.

I do hereby release, discharge, and hold harmless the Canon-McMillan School District, its agents and employees, from any and all liability and claims whatsoever arising from the administration of the above medication to my child/ward which I hereby expressly authorize.

_____ _____
(Signature of Physician) *(Signature of Parent/Guardian)*

Revised 3/22/2023