SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION

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 _____

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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: _____

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EPILEPSY FOUNDATION

San Mateo Union High School District
Authorization for Medication(s) to be Taken During School Hours

Pursuant to Section 49423 and subdivision (b) of Section 49423.6 of the California Education Code, any pupil who is required to take, during the regular school day, prescribed medication may be assisted by a school nurse or other designated school personnel if both of the following conditions are met: (a) The pupil's authorized health care provider executes a written statement specifying, at a minimum, the medication the pupil is to take, the dosage, and the period of time during which the medication is to be take, as well as otherwise detailing (as may be necessary) the method, amount, and time schedule by which the medication is to be taken. (b) The pupil's parent or legal guardian provides a written statement initiating a request to have the medication administered to the pupil or to have the pupil otherwise assisted in the administration of the medication, in accordance with the authorized health care provider's written statement.
With the approval of the pupil's authorized health care provider and the approval of the pupil's parent or legal guardian, a local education agency may allow a pupil to carry medication and to self-administer the medication.

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PARENT: School Name_____

Student Name _____Gender_____ Date of Birth_____
Last First

_____(_____)_____
Physician/Health Care Provider's Name Address Telephone

In regards to the medication authorized below by her/his physician/health care provider:

I request that my student be assisted in taking the medicine(s) at school by authorized persons: Yes_____ No_____

I request that my student be permitted to carry medication & self-medicate her/himself: Yes_____ No_____

I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of the original prescription; strength and dose of medication; and directions for use. If medication is kept at school in the health office, it will be destroyed unless picked up within one week after the end of the school year or end of the medical order. I have read and signed the attached consent (reverse side) to allow designated school personnel to consult with my student's health care provider regarding medication questions. I understand that the medication may be discontinued with written parental request. As parent/guardian of the above-named student, I hereby indemnify and hold harmless from any demands, actions, suits, or liability of any nature or kind, any and all personnel, employees, and agents of the San Mateo Union High School District who may act pursuant to the instruction of my student's health care provider.

_____ _____ (_____)_____(_____)_____
Date Signature of Parent/Guardian Home Phone Emergency

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN:

Diagnosis for which medication is given:_____

Name of medication:_____

Form: _____Dose & route: _____

If medicine is to be given DAILY, at what time(s):_____

If medicine is to be given WHEN NEEDED, describe indications: _____

How soon can it be repeated?: _____ Length of time this treatment is recommended: _____

List significant side effects of medication: _____

In my opinion, this student shows the capability to carry and self-medicate the above medication: Yes_____ No_____

If necessary, this medication may be safely and appropriately administered by trained unlicensed school personnel: Yes_____ No_____ N/A_____

Date: _____ **Signature of Authorized Health Care Provider:** _____

Health Care Provider Address Stamp (required):

SAN MATEO UNION HIGH SCHOOL DISTRICT
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization. I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services at school.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) _____ (2) _____

to provide health information from the above-named student's medical record to and from:

San Mateo Union High School District	**650 North Delaware St., San Mateo, CA 94401**
School District to which disclosure is made	Address/City and State/Zip Code
Sara Devaney, Health Services Manager	**650-558-2222 (Confidential Fax 650-762-0250)**
Contact person at School District	Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

_____

Requested information shall be limited to the following: □ All health information; or □ Disease-specific information as described:

_____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS: California law prohibits the School District from making further disclosure of my health information unless the School District obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that the School District will protect this information as prescribed by the Family Educational Rights Privacy Act (FERPA) and state law and that the information becomes part of the student's education record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs. *If you move to another School District, records will be transferred automatically to that School District.*

YOUR RIGHTS: I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the School District or others have acted in reliance to this Authorization.*

APPROVAL: _____ _____ _____
Printed Name Signature Date

_____ _____
Relationship to Patient/Student Area Code and Telephone Number