School Phone # ___________________
School Fax # ___________________

Seizure Action Plan

This student is being treated for a seizure disorder. The information below may assist if a seizure occurs during school hours or at school activities.

Student Name: ___________ **Date of Birth:** ___________ **School:** ___________
Parent/Guardian: ___________ **Home Phone:** ___________ **Cellular:** ___________
Primary Physician: ___________ **Phone:** ___________ **FAX:** ___________
Neurologist: ___________ **Phone:** ___________ **FAX:** ___________

Physician completes form from this point forward.

Significant Medical History: ___________

Seizure Information

Seizure Type	Length	Frequency	Description	Last Seizure Date

Seizure triggers or warning signs: ___________

Student's response after seizure: ___________

Seizure Response – BASIC	*Additional Individual Student Information:*
* Stay calm and record start of seizure * Keep child safe but Do NOT restrain * Do not put anything in mouth * Stay with child until fully conscious * Document ending time and description of seizure **Tonic-clonic seizure additional response:** • Protect child's head • Turn child on side • Keep airway open • Monitor breathing	Parent requests notification after each seizure ☐Yes ☐No Does student need to leave the classroom after a seizure? ☐Yes ☐No If YES, describe process for returning student to classroom: ___________ ___________ In case of incontinence, parent should provide extra clothing for school so student may return to class as allowed by process above. ☐ Yes ☐ No

Seizure Response – EMERGENCY	A Seizure is Generally Considered an Emergency When:
☐Call 911 for paramedics ☐Contact school nurse ☐Administer emergency medications if indicated below ☐Notify parents or emergency contact (as listed above) ☐Notify doctor listed above ☐Other: ___________	Convulsive (tonic-clonic) seizure lasts longer than 5 minutes Student has repeated seizures without regaining consciousness Student is injured, has diabetes, or is pregnant Student has a first-time seizure Student has breathing difficulties Student has a seizure in water

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

Treatment Protocol During School Hours or School Activities (include daily and emergency medications*)

* Emergency Medication?	*Medication Name	Dosage and Time of Day Given	Common Side Effects and Special Instructions
☐Y or ☐N			
☐Y or ☐N			

Does student have a Vagus Nerve Stimulator? ☐Yes ☐No, If YES, describe magnet use: ___________
Call 911 if still seizing after _______ VNS swipes. Wait _______ minutes between swipes. Give _______ swipes before any emergency medication.

Special Considerations and Precautions (regarding school activities, sports, trips, helmet use, or bus riding after seizure, etc.)

Describe any special considerations or precautions: ______________________________

____

Physician Name: ______________ ***Physician Signature:*** ______________ ***Date:*** ________

I give permission for school staff to contact the physician for consultation and exchange of information as needed.

Signature of Parent or Guardian: ______________ ***Date:*** ________ **Phone Number:** ________

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Parent Request For Assistance with Medication at School

The parent or guardian must complete this page before any medication *(prescription or over-the-counter)* can be given, or taken, at school. *Signature of parent or guardian is required. This form must be renewed each school year or with any change in medication.*

Student Name: ______________ **Date of Birth:** ______________

Parent Request for School Assistance with Medication

I understand that school district regulations require student medication to be maintained in a secure place, under the direction of an adult employee of the school district, and not carried on the person of a student (with the exception of asthma inhalers and epinephrine auto-injectors accompanied by appropriate physician instructions).

A. **I hereby request that the staff of my child's school assist in giving medication** to my child during school hours as stated in the physician instructions. I also give permission to contact the physician for consultation and exchange of information as needed.

Parent or Guardian Signature: ______________ ***Date:*** ____ **Phone Number:** ______________

B. **For ASTHMA INHALER/EPINEPHRINE AUTO-INJECTOR SELF-CARRY requests only**: I hereby request that my student carry and self-administer his/her asthma inhaler or auto-injector. I understand that if my student does not follow the rules and responsibilities of carrying his/her medication, he/she will lose the privilege of carrying such medication. * I also give permission to contact the physician for consultation and exchange of information as needed. I understand that all elementary students and parents must meet with the school nurse.

Parent or Guardian Signature: ______________ ***Date:*** ____ **Phone Number:** ______________

This form must be renewed annually or with any change in treatment or medication.

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* 7/2020