Morris County
Vocational School District

Dear Parent/Guardian,

Your student's health record indicates that he/she has **a history of seizures** and may or may not require use of an emergency medication while in school.

In order to participate in the athletic program, school-sponsored activities and field trips, the following must be completed and submitted to the School Nurse at the *start of EACH school year* :

District Policy requires the following information:

1. **All enclosed paperwork** in this packet must be completed by physician and parent/guardian.
2. **(If applicable) An emergency medication** to be kept in the health office. This medication will only be administered by the school nurse.

***All forms must be dated *after July 1st* for the applicable school year.**

No longer has a history of seizures: Provide a note from your student's physician stating he/she no longer is being treated for seizures.

12th grade students attending CCM/other colleges: These forms are required to be completed and submitted to the health office if your child plans to participate in MCST clubs, athletic teams and school sponsored events and trips

We welcome the opportunity to meet with you and your child to discuss any concerns you may have.

Sincerely,

Ms. Carol Maffei, RN

Ms. Rebecca Reinfeld, RN

School Nurses

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 _____

epilepsy.com

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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

Morris County School of Technology

MODIFED PHYSICAL EDUCATION RECOMMENDATION

Name _____ Grade _____

Excused from (DATES) _____ to _____

Medical Diagnosis/Condition:_____

I HAVE EXAMINED THE ABOVE NAMED STUDENT AND RECOMMEND THAT HE/SHE IS ALLOWED TO PARTICIPATE IN **ONLY** THE FOLLOWING CHECKED ACTIVITIES.

	ACTIVITY		ACTIVITY		ACTIVITY
	Upper Body Resistance Training		Lower Body Resistance Training		Pickleball/Badminton (Racquet Games)
	Stretching Workout		Basketball		Softball
	Walking		Jump Rope		Soccer
	Jogging		Flag Football/Flag Rugby		Team Handball
	Running/Track and Field		Aerobic Activity (other)		Climbing Elements: 1-3 Feet High
	Abdominal Training		Volleyball		Climbing Elements: 10 Feet High
	Stationary Bike		Floor Hockey		Climbing Elements: 30 Feet High (Project Adventure)
	Frisbee		Fitness Assessments		Cooperative Games
	Self Monitored Participation in All Activities		Other (Specify)		

Cardiac Threshold (Maximum HR = 220 – student age):

___ No limitations

___ Limitations:

Heart Rate not to exceed _____ beats/min

Other:_____

Physician's Signature _____ **Date** _____

Physician Stamp: