Seizure Management and Treatment Plan Form

This form is designed to help create a plan for managing student seizures. It consists of questions about seizure history, medications, precautions, and other considerations. This form should be completed jointly by the student's parents and treating physician and provided to the campus nurse or other appropriately identified personnel.

Student Name: _____ **Date of Birth:** _____ **Date:** _____

Parent/Guardian: _____ **Phone:** _____ **Email:** _____

Emergency Contact/ Relationship: _____ **Phone:** _____ **Email:** _____

Seizure Information

Seizure Type	Length (How long it lasts)	Frequency (How often)	What Happens During a Seizure

Known Seizure Triggers or Warning Signs

- ☐ Missed Medicine
- ☐ Emotional Stress
- ☐ Lack of Sleep
- ☐ Physical Stress
- ☐ Flashing Lights
- ☐ Missing Meals
- ☐ Illness with High Fever
- ☐ Alcohol/Drugs
- ☐ Menstrual Cycle
- ☐ Response to specific food or excess caffeine. Specify: _____
- ☐ Other: _____

VNS/Devices

Devices: VNS ☐ RNS ☐ DBS ☐

Date Implanted: _____

Magnet Use/Instructions: _____

Basic first aid to be provided during a seizure

- **STAY** calm, keep calm, begin timing the seizure
- Keep the student **SAFE**: remove harmful objects, don't restrain, and protect their head
- Turn the student on **SIDE** if not awake, keep airway clear, don't put objects in mouth
- **STAY** until the student recovers
- **SWIPE** magnet for VNS
- Write down what happened during the seizure
- Other: _____

When to call 911 – A seizure emergency for the student

- Seizure with a loss of consciousness longer than five minutes and not responding to rescue medicine if available
- Repeated seizures lasting longer than 10 minutes, with no recovery between them and the student is not responding to available rescue medicine
- Difficulty breathing after seizure
- Serious injury occurs or is suspected; seizure in water

When to call student's doctor first

- A change in seizure type, number, or pattern
- Student does not return to usual behavior (i.e., confused for a long period)
- A first time seizure that stops on its own
- Other medical problems or a pregnancy needs to be checked

Developed in collaboration with the Epilepsy Foundation
Form defined by TEC §38.032

Student name: _____ Date of birth: _____

Seizure Emergency Protocol for District Personnel to Follow

- Administer emergency medications
- Contact school nurse: _____
- Call 911; transport to _____
- Notify parent or emergency contact and doctor
- Other: _____

When and What to Do When Rescue Therapy is Needed

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: _____

Student's Response and Care After a Seizure

What type of help is needed? _____
When is the student able to resume usual activity? _____
Does the student need to leave the classroom? Yes ☐ No ☐
If yes, when can the student return to the classroom? _____
Is the student able to manage and understand their seizures? Yes ☐ No ☐

Special Instructions

First Responders: _____
Emergency Department: _____

Daily Seizure Medication

Medication Name	Dosage	Time to be Given	Common Side Effects	Special Instructions

Other Information

Important medical history: _____
Allergies: _____
Epilepsy surgery (type, date, side effects): _____
Diet therapy: Ketogenic ☐ Low-Glycemic ☐ Modified Atkins ☐ Other: _____
Special considerations, instructions, or precautions (i.e., school trips, activities, sports, etc.): _____

Health Care Contacts

Epilepsy Provider: _____ Phone: _____
Primary Care: _____ Phone: _____
Preferred Hospital: _____ Phone: _____
Pharmacy: _____ Phone: _____
Parent/Guardian Signature: _____ Date: _____
Epilepsy Provider Signature: _____ Date: _____

HEALTH SERVICES

MEDICATION AUTHORIZATION FORM

Student Last Name **First Name** **Birthdate** **Grade Level**

This form must be filled out completely in order for school health staff to administer medication to a student. For prescription medications, this form is to be completed and signed by the licensed Healthcare Provider. A new medication authorization form must be completed at the beginning of each school year for each medication, and each time there is a change in the medication's administration instructions.

In compliance with KISD board policy FFAC (local), all medications administered by KISD staff must be:

- Delivered to the clinic by a parent/guardian or his/her designee (responsible adult).
- Prescription medications must be in the original container and be properly labeled. The label must include date prescribed, pharmacy name and address, the serial (prescription) number, student's name, prescriber name, directions for use, and any cautionary statements. It must be prescribed by a physician or dentist licensed to practice in the United States.
- Over the counter medication must be in the original manufacturer's packaging and will only be administered in accordance with manufacturer's guidelines that are age/weight appropriate for the student, unless otherwise prescribed by a physician.
- Medication not retrieved from the clinic by a parent/guardian or his/her designee (responsible adult) by the last calendar day of the current school year will be destroyed in accordance with KISD procedures.
- Over the counter medications may be administered for no longer than 2 weeks with parental approval. A physician's note will be required for any non-prescription medication needed for longer than two weeks.

Medication Name:			**Medication Strength (Number of mg/mcg etc.):**		
Medication Dosage: *(Amount to Be Given)*			**Special Instructions:**		
Time to Be Given:	❑ **Breakfast**	❒ **Lunch**	❒ **PRN/ As Needed**	❒ **_____ (Specific time)**	❒ **Missed AM home dose** *(if verified by parent)*
Period of Administration:		❒ **30 days**	❒ **_____days**	❒ **Duration of school year**	❒ **As needed for emergency**
Route of Administration		❒ **Oral**	❒ **Inhaled**	❒ **Nasal**	❒ **_____**
Reason for Medication:					
Possible Side Effects:					

TO BE COMPLETED BY HEALTHCARE PROVIDER			
HCP Printed Name and Title:		**Phone:**	
HCP Signature:		**Date:**	

I (parent/legal guardian) authorize school personnel to administer the above medication during school hours. I authorize the school's registered nurse or her designee to contact the prescribing physician regarding any clarifications needed regarding the medication listed above as required to assure safe administration. I understand if the circumstances are questionable, the school employee reserves the right to deny my request while investigating. I have reviewed this form; all of the information is accurate.

TO BE COMPLETED BY PARENT / LEGAL GAURDIAN			
Parent/ Legal Guardian Printed Name:		**Phone:**	
Signature:		**Date:**	