Assessment Form: Seizure Disorder

Easton Arts Academy
30 North 4th Street, Easton, Pennsylvania 18042
Phone (484) 546-4230 Fax (610) 829-6076

Date:_____

Grade/Teacher_____

Dear parent/guardian of _____

According to our records your student has a history of seizures or epilepsy.
We would like to find out more about your student's current health status so that we may provide better care. Please complete the questionnaire below and return it to the school nurse.

School Nurse : Claire Wake RN, CSN Email : cwake@eaaecs.org

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1. When did your student's seizures begin? _____
2. What happens during a seizure? Describe. _____
_____
3.When was your student's last seizure? _____
_____
4. What causes your student to have more seizure activity? (circle any applicable)
Illness Fever Stress Tiredenss Other:_____
5. What medications does your student take now? How much? How often?
Medication: _____ How much: _____ How often: _____
Medication: _____ How much: _____ How often: _____
Medication: _____ How much: _____ How often: _____
6. What do you do if your student misses a dose of medicine? _____
_____
7. Please note if you student needs special accomodations for: (circle any applicable)
Physical education class Recess Field Trips Other _____
8. When did you student last see the doctor who treats their seizures? _____
9. Please provide contact information for the doctor who treats your student.
Name: _____
Phone: _____
10. Will your student require medication to be available at school? YES____ NO_____

If YES please have your doctor complete the seizure action plan attached and re to the school nurse and arrange medication drop-off.

Parent/Guardian Signature: _____ Date: _____

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) _____

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Name of Med/Rx _____ How much to give (dose) _____

How to give _____

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 Revised 03/2023 130SRP/PAB1216

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: _____

EPILEPSY FOUNDATION

EASTON ARTS ACADEMY

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS PROCEDURE

Dear Parents/Guardians:

We urge parents to refrain from bringing prescription and over-the-counter (OTC) medications to school unless it is absolutely necessary during school hours. If unavoidable, we **MUST** have the proper Authorization For Medication During School Hours form completed and signed by both the parent/guardian and physician, or medication will not be given. The Pennsylvania Nurse Practice Act forbids the administration of medication by RNs and LPNs without direct authorization from a licensed physician. If your child must take medication at school, the procedure is as follows:

1. An Authorization For Medication During School Hours form is required from the family physician, which shall indicate the necessity of the medication(s) being given to the child during school hours, the name of the medication, the time it is to be given, the dose, and possible reaction(s), if any. This must be done for all prescription, over-the-counter (OTC) medications/remedies, herbal or homeopathic supplements, oils, and/or vitamins.
2. The Authorization For Medication During School Hours form and written statements from physicians are only good for one school year. If the dose or time of the medication changes during the school year, a new form will be required. Forms are available in the nurse's office.
3. Medication is to be brought to school by a parent/guardian in the original pharmacy container and delivered to the school nurse. The container must be labeled with the student's full name, name of physician, dosage of medication to be given, and time when it is to be given. If this procedure is not followed, the medication will not be given. **Do not send medication to school with your child. If your child brings medication to school, it will not be given.**
4. The first dose of any new medication will not be given in school for your child's safety. If this procedure is not followed, the medication will not be given.
5. Students are expected to come to the health room to take their medication at the required time.
6. **A nurse will not be attending any field trips.** If your child needs medical attention during a field trip, teachers and chaperones will care for the child and emergency services will be called if necessary. If any medications are needed during this time, please make arrangements for a parent/guardian to chaperone, so that they may administer the medication themselves.
7. All student medication remaining in the health room at the end of the school year must be picked up by the parent/guardian. If this procedure is not followed, any remaining medication will be discarded.

EASTON ARTS ACADEMY

AUTHORIZATION FOR MEDICATION DURING SCHOOL HOURS

To: School Nurse

Date: _____

My child, _____, must receive the following prescribed medication during school hours in order to maintain sufficient health to participate in the school program. I will provide the medication in an appropriately labeled, original pharmacy container, as well as all over-the-counter (OTC) medication my physician has ordered.

Name of medication: _____

Prescribed dosage: _____

Time schedule: _____

Physician name (please print): _____

Physician telephone number: _____

List of side effects of medication: _____

Diagnosis and necessity of medication during school hours: _____

_____

Expected duration of medication regime: _____

The student is excused from these activities while taking this medication:

Physical Education: _____ Other: _____

PHYSICIAN SIGNATURE: _____

As the parent/guardian, I do hereby release, discharge, and hold harmless, Easton Arts Academy and its agents and employees, from any and all liability and claims whatsoever in connection with the administration of the above medication to my child.

PARENT/GUARDIAN SIGNATURE: _____

The student may carry his/her rescue **inhaler / Epi-Pen and has demonstrated that he/she can properly self-administer and accepts full responsibility for the administration of his/her emergency medication.

Prescriber/Physician: _____ Date: _____

Parent/Guardian: _____ Date: _____