

## Individualized Seizure Action Plan (SAP) for the 20\_\_\_\_-20\_\_\_\_ School Year

This student is being treated for a seizure disorder. The information provided below is intended to assist school personnel should a seizure occur during school hours.

### The Following is to be Completed by the Parent

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Grade \_\_\_\_\_ Homeroom/Teacher \_\_\_\_\_

Allergies \_\_\_\_\_

Significant Medical History \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone Number \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone Number \_\_\_\_\_

### The Following is to be Completed by the Medical Provider

Seizure Type \_\_\_\_\_ Date of Seizure Diagnosis \_\_\_\_\_

Other Medical Diagnosis \_\_\_\_\_

How long does a seizure typically last? \_\_\_\_\_ How often? \_\_\_\_\_

What happens/typical symptoms? \_\_\_\_\_

Current Medication(s) \_\_\_\_\_

\_\_\_\_\_

Special Considerations/Safety Precautions while at school (including after-school care programs, field trips – addition space provided on page 2): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Student Specific Seizure Emergency Plan Per Medical Provider

If seizure (cluster, # or length) \_\_\_\_\_

Name of rescue medication/dose \_\_\_\_\_

Dosing instructions \_\_\_\_\_

Special instructions/considerations if rescue medication is given (when to call EMS, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*Continued Page 2**

**SPECIAL INSTRUCTIONS**

First Responders: \_\_\_\_\_

\_\_\_\_\_

Emergency Department: \_\_\_\_\_

\_\_\_\_\_

- |                                                                                               |
|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> First Aid – Stay. Safe. Side.                                        |
| <input type="checkbox"/> Give rescue therapy according to Emergency Plan per Medical Provider |
| <input type="checkbox"/> Notify emergency contact at # _____                                  |
| <input type="checkbox"/> Call 911 for transport to _____                                      |
| <input type="checkbox"/> Other _____                                                          |

**Special Considerations/Safety Precautions while at school (Continued):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Treating Physician \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_ (rev 4/2023)

## Permission Form for Administration of Medications at School

I hereby certify that it is necessary for Maclay Student

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade Level: \_\_\_\_\_

Known ALLERGIES: \_\_\_\_\_

To be given during the school day, including when they are away from school property on official school business.

**Medication (#1):** \_\_\_\_\_ **Reason for Medication:** \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time(s) of administration: \_\_\_\_\_

Beginning date: \_\_\_\_\_ Ending date: \_\_\_\_\_ Amount of liquid or pills: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

**Medication (#2):** \_\_\_\_\_ **Reason for Medication:** \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time(s) of administration: \_\_\_\_\_

Beginning date: \_\_\_\_\_ Ending date: \_\_\_\_\_ Amount of liquid or pills: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

**Medication (#3):** \_\_\_\_\_ **Reason for Medication:** \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time(s) of administration: \_\_\_\_\_

Beginning date: \_\_\_\_\_ Ending date: \_\_\_\_\_ Amount of liquid or pills: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

### Emergency Contacts:

Name: \_\_\_\_\_ Number: \_\_\_\_\_

Doctors Name: \_\_\_\_\_ Number: \_\_\_\_\_

Prescription and non-prescription medication shall come in original container. Prescription labels will be the current, official pharmacy label will designate the patient's name, dosage and time of administration and prescribing doctor. Changes in the medication times can be made by written prescription from physician. This permission form is valid for current school year only. I hereby consent to protected health information being used and disclosed to carry out treatment or healthcare operations of my child. I understand that Maclay School may need to give and receive protected provider listed above, and I hereby authorize the exchange of information as needed to carry out the treatment or health care operations of my child. I also give permission for the information on this form to be reviewed and utilized by the staff of this school and any school health personnel providing school health services at Maclay School for the limited purposes of meeting my child's health and education needs.

I hereby authorize Maclay School and their officers, employees, agents, to assist my child with medications administration and/or to supervise self-administration of medications. I acknowledge and agree that non-health professionals, trained in medication administration may assist my child with medication administration. I hereby release, indemnify, and hold harmless Maclay School and any of their officers, employees, contractor, and agents against all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold Maclay School and their officers, employees, contractors, and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them rising from harm to any persons caused by my child's actions with regards to self-carried medication.

It is understood by the undersigned that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances. By signing below, the Parent/guardian represents and warrants that the medication provided to Maclay School is as described above; furthermore, the parent/guardian agrees to hold Maclay school harmless from any claims and/or damages arising out of or related to the provision of the medication provided by the parent/guardian as described above. Parents are requested to pick up any leftover medication within one week after the ending date. Medication left after that time will be discarded.

I am the parent/guardian of the child named above. I give permission for the information on this form to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services for the limited purposes of meeting my child's health and educational needs.

Date: \_\_\_\_\_ Parent/ Guardian Signature \_\_\_\_\_ (rev 8/2025)