



SEIZURE ACTION PLAN FOR SCHOOL

Student Name: _____ D.O.B. _____

Teacher: _____ Physician Phone: _____

EMERGENCY CONTACTS

<u>Name</u>	<u>Relationship</u>	<u>Home #</u>	<u>Work #</u>	<u>Cell #</u>
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1. _____

2. _____

3. _____

Type of seizure: _____

What does the seizure look like and how long does it usually last?

Possible triggers that should be avoided: _____

Does student need any special activity adaptations/protective equipment (e.g., helmet) at school? _____

_____ No _____ Yes (explain) _____

Is student allowed to participate in physical education and other activities?

_____ No _____ Yes (explain) _____

ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES? _____ No _____ Yes

(List below the medications needed)

_____ **Vagus Nerve Stimulator implant (see VNS management order attached)**

MEDICATIONS AMOUNT TAKEN HOW OFTEN AND FOR WHAT SIGNS

1. _____

2. _____

3. _____

Possible side effects that must be reported to parent or physician:



IF GENERALIZED SEIZURE OCCURS:

1. If falling, assist student to floor, turn to side.
2. Loosen clothing at neck and waist; protect head from injury.
3. Clear away furniture and other objects from area.
4. Have another classroom adult direct students away from area.

5. TIME THE SEIZURE.

6. Allow seizure to run its course; **DO NOT** restrain or insert anything into student's mouth. Do not try to stop purposeless behavior.
7. During a general or grand mal seizure expect to see pale or bluish discoloration of the skin or lips. Expect to hear noisy breathing.

IF SMALLER SEIZURE OCCURS (e.g., lip smacking, behavior outburst, staring, twitching of mouth or hands)

1. Assist student to comfortable, sitting position.
2. **TIME THE SEIZURE.**
3. Stay with student, speak gently, and help student get back on task following seizure.

IF STUDENT EXHIBITS:

1. Absence of breathing or pulse.
2. Seizure of 10 minutes or greater duration.
3. Two or more consecutive (without a period of consciousness between) seizures which total 10 minutes or greater.
4. Continued unusually pale or bluish skin or lips or noisy breathing after the seizure has stopped.

INTERVENTION:

1. **Call 911.**
2. **START CPR for absent breathing or pulse.**

WHEN SEIZURE COMPLETED:

1. Reorient and assure student.
 - a. Assist change into clean clothing if necessary.
 - b. Allow student to sleep, as desired, after seizure.
 - c. Allow student to eat, as desired, once fully alert and oriented.
2. A student recovering from a generalized seizure may manifest abnormal behavior such as incoherent speech, extreme restlessness, and confusion. This may last from five minutes to hours.
3. Inform parent immediately of seizure via telephone conversation if:
 - a. Seizure is different from usual type or frequency or has not occurred at school in past month.
 - b. Seizure meets criteria for 911 emergency call.
 - c. Student has not returned to "normal self" after 30-60 minutes.
4. Record seizure on Seizure Activity Log.



SIGNATURE

PREPARATORY

If you want additional care given, describe action here:

If symptoms are _____

Give _____ (medication/dose/route)

Possible side effects _____

Physician Signature _____ Date _____

Print Name _____ Phone _____

I want this plan implemented for my child, _____, in school. I hereby give my permission for exchange of confidential information contained in the record of my child between the nurse and physician and my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

Parent/Guardian Signature: _____ Date: _____

Approved by School Nurse

School Nurse Signature: _____ Date: _____



SIGNATURE PREPARATORY

MEDICATION PRESCRIBER/PARENT AUTHORIZATION FOR VAGUS NERVE STIMULATOR (VNS)

STUDENT INFORMATION

Student's Name _____

Date of Birth: ____/____/____ Grade _____ Teacher _____

Known drug allergies/reactions If drug allergies, list: _____ Weight: _____ lbs.

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

START DATE: _____ STOP DATE: _____

Procedure: Swiping magnet over student's VNS

Reason for procedure: To shorten duration of, or stop, seizure activity.

How & frequency r/t swipe delivery: Swipe magnet over VNS for full 1-2 second time period, at onset of seizure activity.

Repeat swipe X _____ if seizure activity does not cease after _____ minute(s).

If magnet is held in place over the VNS for longer than 60 seconds at one time, the generator will be turned off until the magnet is removed. Once magnet is removed, the device will resume its normal cycle.

Do you recommend the magnet be kept "on person" by the student? ☐ Yes ☐ No

If "no", storage location of magnet will be identified in student's Individualized Healthcare Plan.

Potential Contradictions/Adverse Reactions: _____

Printed Name of Licensed Healthcare Provider

Signature of Licensed Healthcare Provider Date Phone Fax

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to assist my child in the above procedure, and to delegate to trained, unlicensed school personnel, the task of assisting my child with the above prescribed procedure, in accordance with administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure. Procedure equipment or supplies must be registered with the school nurse or his/her designee.

Signature of Parent/Guardian Date Phone

Letter to Parent Regarding Administration of Medication in School

Dear Parent:

Our school has a written policy to assure the safe administration of medication to students during the school day. If your child must have medication of any type, including over the counter drugs, given during school hours, you have the following choices:

1. You may come to school and give the medication to your child at the appropriate time(s).
2. You may obtain a copy of a medication form ***Request for Medication Administration in School*** from the school website or health office. Take the form to your child's licensed healthcare provider and have him/her complete the form. This form must be completed by the provider for all prescription drugs and over-the-counter medications the form must be signed by the provider and by you, the parent or guardian. Prescription medicines must be brought to school in the pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over the counter drugs must be received in the unopened original container, labeled with your child's name, and will be administered according to the written instructions on the medication at school form.
3. You may discuss with your provider an alternative schedule for administering medication (i.e. outside of school hours). Please keep in mind that scheduled medication will not be given in the first and last hour of each school day.
4. Self-Medication: Students requiring medication for asthma, anaphylactic reactions, and diabetes may self-medicate with physician authorization, parent permission, student agreement for self-carried medication, and a signed blood-borne pathogen/medical waste acknowledgement. Students must demonstrate the necessary knowledge and developmental maturity to safely assume responsibility for, and management of self-carry medications. **If found incompetent by health office personnel, the medication will need to be kept in the health office with the appropriate forms filled out.**
5. School personnel will not administer any prescription or over-the-counter medication to a student unless the school has received a completed *Request for Medication Administration* form that has been signed by both the provider and parent/guardian, and the medication has been received in an appropriately pharmacy-labeled container.

If you have questions about the policy, or other issues related to the administration of medication at schools, please contact the school health office.

Thank you for your cooperation,

Health Office Representative

Date



The Responsibility of the Parent or Legal Guardian

1. Limit the medications that must be given during the school day to those necessary in order to maintain the child at school. ____ *Initials*
 2. Provide a written request for school personnel to administer the medication. This should be in the form of a request/permission form (i.e., Request for Medication form). Return completed form to school. A separate parent request/permission form must be completed for each medication given at School. ____ *Initials*
 3. Parents may choose to administer the medication at school themselves. ____ *Initials*
 4. Complete an Authorization form, signed by a health care provider licensed to prescribe medications, which includes the following:
 - a. Name of child
 - b. Name of medication
 - c. Date it was prescribed
 - d. Dosage
 - e. How the medicine is to be given at school
 - f. When the medicine will be given at school
 - g. Special instructions about the child receiving the medication or about the medicine itself.
 - h. Until what date the medicine is to be given at school
 - i. Possible side effects of the medication
 - j. Possible adverse reactions to the medication
 - k. Name of the health care provider and how to locate or communicate with him/her if necessary
____ *Initials*
 5. Provide a completed action plan form if your child has the following diagnoses and will be self-carrying medication/supplies: Asthma, allergies requiring an Epi-pen, Seizures, and/or Diabetes ____ *Initials*
 6. Provide each medication in a separate pharmacy-labeled container that includes the child's name, name of the medication, the exact dose to be given, the number of doses in the original container, the time the medication is to be given, how it is to be administered, and the expiration date of the medication. The medication pharmacy label on the container must match the doctor's order (request for medication administration).
- Note: The parent should request of the pharmacist to provide two labeled containers – one for home use and one for school use – if child needs to be given medication both at home and at school. ____ *Initials*
7. Over the counter medications administered at school should be provided in their original packaging labeled with the student's name. ____ *Initials*
 8. Provide the school with new, labeled containers when dosage or medication changes are prescribed. ____ *Initials*
 9. Retrieve all unused medications from school when medications are discontinued, and /or within 3 days of the date the school year ends. Signature Preparatory reserves the right to discard the medication if not picked up within 3 days ____ *Initials*
 10. Maintain communication with the school staff regarding any changes in the medical treatment and child's need at school. ____ *Initials*

Student Name: _____ DOB: _____

Parent/Guardian Signature

Date

Health Office Representative

Date



SIGNATURE

PREPARATORY

Request for Medication Administration in School

To be completed by physician

Name of Student: _____

Medication: (each medication is to be listed on a separate form) _____

Dosage and Route: _____

Time(s) medication is to be given: a.m.: _____ p.m.: _____ PRN: _____

Note: Medication will be given as close to prescribed time as possible but may be given up to one hour before or after prescribed time. Please advise if there is a time specific concern regarding administration.

Significant Information (include side effects, toxic reactions, reactions if omitted, etc.): _____

Contraindications to administration: _____

Physician (printed) Name: _____ Address: _____

Physician Contact Information: Phone: _____ Fax: _____

Physician's Signature: _____ Date: _____

I hereby give permission for my child (named above) to receive medication during school hours; administered by the health aide or director appointed staff. The medication will be furnished by me in the original container, labeled with the child's name and is to be given as stated above. I understand that medication will NOT be accepted if brought in by my child or is loose in a baggie, envelope or other container. I will count the medication with the staff and co-sign off on the medication. I give my consent to Signature Preparatory Academy to contact the prescribing physician and exchange relevant medical information to clarify this medication order. I hereby release the School Board and their agents and employees from all liability that may result from my child taking this medication.

Parent/Guardian signature _____ Date: _____

Please document medication count *with parent present* below:

Date	Medication Name	Count	Expiration Date	Parent signature	Employee initials



SIGNATURE

PREPARATORY

Medication Administration Record (2025-2026)

Student Name: _____ DOB: _____

Medication Name/Dosage/Route: _____

A separate sheet is used for each medication or treatment

Key : A=Absent FT= Field Trip NS= No Show NM= No Medication in office RF= Refused ED= Early Dismissal

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Date	Time	Person Administering (Name & Initials)