

**FRANKLIN SPECIAL DISTRICT
SEIZURE EMERGENCY ACTION PLAN**

PARENT/GUARDIAN TO COMPLETE THE SECTION BELOW

Student Name: _____ Date of Birth: _____

Father's Name: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Mother's Name: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Emergency Contact if parent not available: _____

(Authorized to act in behalf of parents if we are unable to contact parent)

Home Phone: _____ Cell: _____ Work Phone: _____

Physician Name: _____ Phone: _____ Fax: _____

SEIZURE HISTORY: TO BE COMPLETED BY PARENT/GUARDIAN

Type of seizures: _____

Triggers which start seizure: _____

Possible seizure signs: _____

Usual length of seizure: _____

Describe previous seizures including frequency of past seizures and date of last seizure:

Please list all current medications taken at home:

- **EMERGENCY SEIZURE MEDICATIONS MUST BE PROVIDED BY THE PARENT/GUARDIAN TO BE KEPT AT SCHOOL AND ADMINISTERED ACCORDING TO THE PHYSICIAN'S ORDERS BY A LICENSED NURSE.**
- **IN THE EVENT EMERGENCY MEDICATIONS WITH A PHYSICIAN ORDER HAVE NOT BEEN PROVIDED FOR THE STUDENT, OR THE LICENSED NURSE IS NOT AVAILABLE, THE GUIDELINES SET FORTH IN THE SCHOOL RESPONSE PLAN FOR CALLING 911 WILL BE FOLLOWED.**

EXPIRED MEDICATIONS MUST BE REPLACED. AN EXPIRED MEDICATION CANNOT BE ADMINISTERED AT SCHOOL.

I (parent/guardian) will notify the school nurse if emergency seizure medications are administered outside of school. Diastat is not to be used more than 5 times/month and not more than once in five days. I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent for school authorities to communicate with the health care providers when necessary and for the health care provider to provide this and other information regarding my child's health needs to the school nurse, principal or designated assistive personnel. I understand that health information regarding my child will be kept confidential, but shared with school personnel on a need-to-know basis in order to protect the health and safety of my child. I release the Franklin Special District from any legal claim and assume full responsibility for any adverse reactions my child may suffer as a result of taking or failing to take the medication. I understand that my child will be administered medications and emergency treatment as indicated by the physician's orders on the other side of this form. This treatment will be administered even if a parent/guardian cannot be reached.

I agree that this individualized healthcare plan meets the needs of my child. I understand and agree that my child may be assisted with medication administration/procedures on field trips or in the absence of a school nurse by unlicensed trained personnel (such as a teacher). I understand that if emergency medications have not been provided by the parent/guardian, 911 will be called.

Parent/Guardian Name

Parent/Guardian Signature

Date

Nurse Name

Nurse Signature

Date

**FRANKLIN SPECIAL SCHOOL DISTRICT
SEIZURE INDIVIDUALIZED HEALTHCARE PLAN**

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

PHYSICIAN TO COMPLETE THE SECTION BELOW

Type of seizures: _____ Age Diagnosed: _____

Triggers that start seizure: _____

Possible seizure signs: _____

SCHOOL RESPONSE PLAN

*Help the student to the floor, place the student on his or her side if drooling or vomiting.

*Clear any objects out of the way, move other students outside the classroom.

*Do not try to stop the seizure, hold the child down or place anything in student's mouth.

*Monitor the child's breathing.

*Stay calm, **note how long the seizure lasts**.

*Contact School Nurse or School Response Team.

*Comfort, reassure and reorient the student.

*Clinic nurse will administer emergency medications per orders.

CALL 911 if:

*Absence of breathing and/or pulse.

*Seizure of 5 minutes or greater.

*Two or more consecutive seizures (no consciousness between) seizures which total 5 or more minutes.

*Continued unusually pale or bluish skin/lips or noisy breathing AFTER the seizure has stopped.

EMERGENCY MEDICATION ORDERS

Name of Medication	Dosage and Route	Indications(When to Administer)

CALL 911 if anti-seizure medications are administered. Rectal Diazepam may not be used more than 5 times/month or more than once in 5 days.

Quantity Provided: _____ Expiration Date: _____

Purpose of Medication: _____ Possible side effects: _____

Other considerations, allergies or MD orders _____

Emergency seizure medications will be administered only by a licensed nurse when prescribed by the physician and provided by the parents. In the absence of a licensed nurse, 911 will be called following the 911 protocol above.

I authorize school personnel to implement this Seizure Emergency Plan as described above:

Physician Name (Please Print)

Physician Signature

Date

Physician Phone Number

Physician Fax Number

Date