

# SEIZURE ACTION PLAN (SAP)



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) \_\_\_\_\_

How to give \_\_\_\_\_

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

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

How to give \_\_\_\_\_

## Care after seizure

What type of help is needed? (describe) \_\_\_\_\_

When is person able to resume usual activity? \_\_\_\_\_

## Special instructions

☐ Student may participate in before and after school activities, including varsity level sports when no nurse will be present. 911 will be called if needed.

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

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

## Daily seizure medicine

| Medicine Name | Total Daily Amount | Amount of Tab/Liquid | How Taken<br>(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: \_\_\_\_\_



## Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

### Contact Information

|                                           |             |               |      |
|-------------------------------------------|-------------|---------------|------|
| Student's Name                            | School Year | Date of Birth |      |
| School                                    | Grade       | Classroom     |      |
| Parent/Guardian                           | Phone       | Work          | Cell |
| Parent/Guardian Email                     |             |               |      |
| Other Emergency Contact                   | Phone       | Work          | Cell |
| Child's Neurologist                       | Phone       | Location      |      |
| Child's Primary Care Doctor               | Phone       | Location      |      |
| Significant Medical History or Conditions |             |               |      |

### Seizure Information

1. When was your child diagnosed with seizures or epilepsy? \_\_\_\_\_

2. Seizure type(s)

| Seizure Type | Length | Frequency | Description |
|--------------|--------|-----------|-------------|
|              |        |           |             |
|              |        |           |             |
|              |        |           |             |
|              |        |           |             |

3. What might trigger a seizure in your child? \_\_\_\_\_

4. Are there any warnings and/or behavior changes before the seizure occurs? ☐ YES ☐ NO  
If YES, please explain: \_\_\_\_\_

5. When was your child's last seizure? \_\_\_\_\_

6. Has there been any recent change in your child's seizure patterns? ☐ YES ☐ NO  
If YES, please explain: \_\_\_\_\_

7. How does your child react after a seizure is over? \_\_\_\_\_

8. How do other illnesses affect your child's seizure control? \_\_\_\_\_

### Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? ☐ YES ☐ NO  
If YES, what process would you recommend for returning your child to classroom:

### Basic Seizure First Aid

- Stay calm & track time
  - Keep child safe
  - Do not restrain
  - Do not put anything in mouth
  - Stay with child until fully conscious
  - Record seizure in log
- For tonic-clonic seizure:**
- Protect head
  - Keep airway open/watch breathing
  - Turn child on side

### Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? ☐ YES ☐ NO

If YES, please explain:

### A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

### Seizure Medication and Treatment Information

13. What medication(s) does your child take?

| Medication | Date Started | Dosage | Frequency and Time of Day Taken | Possible Side Effects |
|------------|--------------|--------|---------------------------------|-----------------------|
|            |              |        |                                 |                       |
|            |              |        |                                 |                       |
|            |              |        |                                 |                       |

14. What emergency/rescue medications are prescribed for your child?

| Medication | Dosage | Administration Instructions (timing* & method**) | What to Do After Administration |
|------------|--------|--------------------------------------------------|---------------------------------|
|            |        |                                                  |                                 |
|            |        |                                                  |                                 |

\* After 2<sup>nd</sup> or 3<sup>rd</sup> seizure, for cluster of seizure, etc.

\*\* Orally, under tongue, rectally, etc.

15. What medication(s) will your child need to take during school hours? \_\_\_\_\_

16. Should any of these medications be administered in a special way? ☐ YES ☐ NO

If YES, please explain: \_\_\_\_\_

17. Should any particular reaction be watched for? ☐ YES ☐ NO

If YES, please explain: \_\_\_\_\_

18. What should be done when your child misses a dose? \_\_\_\_\_

19. Should the school have backup medication available to give your child for missed dose? ☐ YES ☐ NO

20. Do you wish to be called before backup medication is given for a missed dose? ☐ YES ☐ NO

21. Does your child have a Vagus Nerve Stimulator? ☐ YES ☐ NO

If YES, please describe instructions for appropriate magnet use:

### Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

- |                                                     |                                                                |
|-----------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> General health _____       | <input type="checkbox"/> Physical education (gym/sports) _____ |
| <input type="checkbox"/> Physical functioning _____ | <input type="checkbox"/> Recess _____                          |
| <input type="checkbox"/> Learning _____             | <input type="checkbox"/> Field trips _____                     |
| <input type="checkbox"/> Behavior _____             | <input type="checkbox"/> Bus transportation _____              |
| <input type="checkbox"/> Mood/coping _____          | <input type="checkbox"/> Other _____                           |

### General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? \_\_\_\_\_

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ☐ YES ☐ NO

Dates \_\_\_\_\_

Updated \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# ROXBURY TOWNSHIP PUBLIC SCHOOLS

Succasunna, NJ

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## Medication Policy

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Effective June 2020, Roxbury Township Board of Education adopted revised Policy #[5330](#) regarding the administration of medication to students. According to the policy, "medication" means any prescribed or over-the-counter medicine. This includes such medications as Tylenol, aspirin or cough drops.

The following guidelines **must** be followed when the administration of medication in school is necessary:

1. The parent or guardian **and** private physician must provide a written request for the administration of the prescribed medication at school. The physician's written order must include the following:
  - a. Name of the student
  - b. Diagnosis or type of illness involved
  - c. Name of the medication
  - d. Dosage
  - e. Time of administration
  - f. Time when its use will be discontinued
  - g. Side effects
2. Currently dated **medication must be brought to the Health Office by the parent/guardian in the original labeled container**. Most pharmacies will provide you with an extra bottle properly labeled for school.
3. Medication no longer required must be promptly removed by the parent/guardian.
4. Medication will only be administered to students in school by the school physician, a certified or non-certified school nurse, a substitute school nurse employed by the district or the student's parent/guardian. Students with asthma or other potentially life threatening illnesses will be allowed to self-administer medication when a nurse is not physically present at the scene. Permission for such administration must be on file in the office of the school nurse and comply with the conditions for granting permission.

Medication permission slips may be obtained from your school nurse or on-line at [www.roxbury.org/Page/749](http://www.roxbury.org/Page/749).

Thank you for your attention to this matter.

ROXBURY SCHOOL DISTRICT | Medication Administration Daily Log (to be completed for each medication)

School Year 20\_\_ / 20\_\_ Student's School (Underline/Circle)→ RHS EMS L/R Franklin Jefferson Kennedy Nixon

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Grade/Teacher \_\_\_\_\_

**Parent/Guardian's signature granting permission for administration of medication/sharing of information with appropriate staff members:**

Name of Parent/Guardian \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Name & Dosage of Medication \_\_\_\_\_ Route \_\_\_\_\_ Time(s) Given in School \_\_\_\_\_

Start Date \_\_\_\_\_ End Date \_\_\_\_\_ (Medication must be in the original container as dispensed by the pharmacy or physician)

Reason for medication \_\_\_\_\_

Physician's Printed Name \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

Office Stamp of Physician →  
or Attach Official Letterhead of Physician

|     | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|-----|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Aug |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Sep |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Oct |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Nov |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Dec |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Jan |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Feb |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Mar |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Apr |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| May |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Jun |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

| Initial  | &     | Signature of Person administering medication | Codes^ |                                                         |
|----------|-------|----------------------------------------------|--------|---------------------------------------------------------|
| 1. _____ | _____ | _____                                        | _____  | ( A ) Absent                                            |
| 2. _____ | _____ | _____                                        | _____  | ( O ) No Show                                           |
| 3. _____ | _____ | _____                                        | _____  | ( W ) Dosage Withheld                                   |
| 4. _____ | _____ | _____                                        | _____  | ( N ) No Medication Available                           |
|          |       |                                              |        | ( E ) Early Dismissal                                   |
|          |       |                                              |        | ( F ) Field Trip                                        |
|          |       |                                              |        | ( X ) No School (e.g. Holiday; Weekend; Snow Day; etc.) |

**This permission form is effective only for the school year for which it is granted and must be renewed each school year.**

[illegible]