



# Aurora City Schools

[www.aurora-schools.org](http://www.aurora-schools.org)

Board of Education  
102 E. Garfield Rd.  
Aurora, OH 44202  
330-562-6106  
Fax: 330-562-4892

Miller Elementary  
646 S. Chillicothe Rd.  
Aurora, OH 44202  
330-562-6199  
Fax: 330-995-5459

Craddock Elementary  
105 Hurd Rd.  
Aurora OH 44202  
330-562-3175  
Fax: 330-954-2087

Leighton Elementary  
121 Aurora-Hudson Rd.  
Aurora OH 44202  
330-562-2209  
Fax: 330-562-2265

Harmon Middle School  
130 Aurora-Hudson Rd.  
Aurora OH 44202  
330-562-3375  
Fax: 330-562-4796

Aurora High School  
109 W. Pioneer Trail  
Aurora OH 44202  
330-562-3501  
Fax: 330-562-3588

Dear Parent/Guardian,

**Sarah's Law** mandates that all students with a diagnosed seizure disorder must have an individualized Seizure Action Plan (SAP) on file with the school. This plan is crucial for ensuring that our staff is fully prepared to provide appropriate care in the event of a seizure.

The Seizure Action Plan is a detailed document that outlines the specific actions that should be taken if your child experiences a seizure while at school. It includes essential information such as:

- Your child's medical history and seizure type(s)
- Specific instructions on what to do during and after a seizure
- Medications your child may need
- If the student is authorized to self carry rescue medications, a physician signature and Parent/Guardian signature is required
- Emergency contact information
- Any other relevant details provided by your child's healthcare provider

All medications must be in their original containers. Medication **MAY NOT** be sent to school with the student (unless approved to self carry). Parent/Guardian to deliver medication to school.

Please call your child's designated school clinic if you have questions, we would be happy to help you.

**Ohio Department of Health  
Seizure Action Plan (SAP)  
For a Student with an Active Seizure  
Disorder (Epilepsy) Diagnosis**  
Per ORC 3313.7117 and 3313.713



**School Year:**

20\_\_\_\_ / 20\_\_\_\_

SAP is effective only for the school year in which it is written.

**A. STUDENT INFORMATION (This section completed and signed by Parent/Guardian)**

Student:	DOB:	Grade:	School:
Parent/Guardian:	Phone:		Email:
Treating Practitioner:	Phone:		Fax:
School Nurse/School Administrator:	School Phone:		Fax:

As parent/guardian of the above-named student, I give permission for my student's healthcare provider to complete this Seizure Action Plan/Seizure Medication Protocol and share the information with the school nurse/school administrator. I understand the information contained in this plan will be shared with school staff per ORC 3313.7117.

- ✓ I authorize an employee of the school to administer seizure care and prescribed drugs listed in this plan.
- ✓ I understand that additional parent/prescriber signed statements will be necessary if the plan is changed.
- ✓ I also authorize the licensed health care professional to talk with the prescriber or pharmacist to clarify the Seizure Action Plan and/or drug(s) to be given.
- ✓ The Seizure Action Plan must be received by the school nurse, school administrator, or a school employee.
- ✓ I understand that a drug prescribed in this plan shall be provided in the container in which it was dispensed by the prescriber or a licensed pharmacist, to the school nurse or other designated person at the school who is authorized to administer the drug.

Parent/Guardian Name (print):	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:

**B. SEIZURE CARE INFORMATION**

Seizure Type/Description	Length	Frequency

Seizure triggers or warning signs:

Student specific information:

**Does student need to leave the classroom after a seizure?**  YES  NO  
If YES, describe process for returning student to classroom:

**SPECIAL CONSIDERATIONS:**

Bus/Transportation:

Field Trips:

Sports:

Emergency situation such as "Lock Down":

Other:

<b>Student Name</b>		<b>DOB:</b>	<b>School Year:</b>
<b>SEIZURE CARE INFORMATION (continued) - Marks all behaviors that apply to student</b>			
<b>If you see this:</b>		<b>Do this:</b>	
<input type="checkbox"/> Sudden cry or squeal. <input type="checkbox"/> Loss of bowel or bladder control. <input type="checkbox"/> Staring. <input type="checkbox"/> Rhythmic eye movement. <input type="checkbox"/> Lip smacking. <input type="checkbox"/> Gurgling or grunting noises. <input type="checkbox"/> Falling down. <input type="checkbox"/> Rigidity or stiffness. <input type="checkbox"/> Thrashing or jerking. <input type="checkbox"/> Change in breathing. <input type="checkbox"/> Blue color to lips. <input type="checkbox"/> Froth from mouth. <input type="checkbox"/> Loss of consciousness. <input type="checkbox"/> Other (specify): _____		<input type="checkbox"/> Stay calm and track time. <input type="checkbox"/> Report symptoms and duration to parent. <input type="checkbox"/> Keep student safe. <input type="checkbox"/> Do not restrain. <input type="checkbox"/> Protect head. <input type="checkbox"/> Keep airway open/watch breathing. <input type="checkbox"/> Turn student on side. <input type="checkbox"/> Do not put anything in mouth. <input type="checkbox"/> Do not give fluids or food during or immediately after seizure. <input type="checkbox"/> Stay with student until fully conscious. <input type="checkbox"/> Ensure symptoms resolve before student leaves classroom. <input type="checkbox"/> Administer prescribed seizure rescue medication. <input type="checkbox"/> Swipe VNS magnet. o Describe magnet use and location of implanted device on student: _____ <input type="checkbox"/> Other (specify): _____	
<b>Expected behavior after a seizure:</b>		<b>When to CALL 911</b>	
<input type="checkbox"/> Tiredness. <input type="checkbox"/> Weakness. <input type="checkbox"/> Sleeping, difficult to arouse. <input type="checkbox"/> Somewhat confused. <input type="checkbox"/> Regular breathing. <input type="checkbox"/> Other (specify): _____  Follow-Up with: <input type="checkbox"/> Notify school nurse or school administrator. <input type="checkbox"/> Document observations.		<input type="checkbox"/> Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available. <input type="checkbox"/> Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available. <input type="checkbox"/> Difficulty breathing after seizure. <input type="checkbox"/> Serious injury occurs or suspected, seizure is in water. <input type="checkbox"/> Other (specify): _____	
<b>SEIZURE MEDICATION PROTOCOL DURING SCHOOL HOURS (Completed by Treating Practitioner)</b>			
Name of Medication/Dose (how much)	Route (how to give)	When to give (seizure cluster, # or length)	
<b>Licensed Healthcare Professional Authorized to Prescribe</b>			
Treating Practitioner Name (print):		Signature:	<b>Authorization Dates:</b> <b>Start Date:</b> _____ <b>Stop Date:</b> _____
Phone Number:		Practice Address:	

<b>Student Name</b>	<b>DOB:</b>	<b>School Year:</b>
<b>C. FOR SCHOOL USE ONLY (Completed by School Nurse or School Administrator).</b>		
<b>EMERGENCY SEIZURE RESCUE MEDICATION and SEIZURE DISORDER CARE</b>		
Designated person(s) trained to give seizure disorder care, seizure medication, and/or use VNS magnet:		
<b>School Employee(s) (specify name)</b>	<b>Dates of Training (Required every 2 years)</b>	
Location of seizure rescue medication (must be locked but accessible) and/or VNS magnet:		
<b>SCHOOL NURSE or SCHOOL ADMINISTRATOR</b>		
<b>Distribution of and training on the Seizure Action Plan (this form)</b> to the school staff who (1) regularly interacts with the student; (2) has legitimate educational interest in the student or is responsible for direct supervision of the student; (3) is responsible for transportation of the student to and from school.		
<b>Specify Names</b>	<b>Date SAP received/trained</b>	
<input type="checkbox"/> Front office/administrative staff:		
<input type="checkbox"/> Teacher(s)/classroom staff:		
<input type="checkbox"/> Transportation:		
<input type="checkbox"/> Other(s):		
Seizure Action Plan (this form) is the responsibility of and maintained in the office of:		
<input type="checkbox"/> School Nurse and/or <input type="checkbox"/> School Administrator		
School Nurse Signature:	Date:	
School Administrator Signature:	Date:	
<b>ADDITIONAL INFORMATION FOR SCHOOL USE</b>		