

**Johnson City Schools
Health Services
Seizure Emergency Action Plan**

PARENT/GUARDIAN - Complete page 1 sign on page 2. Physician Complete page 2

Name: _____ Date of Birth: _____ School Year: _____
School: _____ Grade: _____ Teacher/Homeroom: _____
Parent/Guardian: _____ Phone: _____ Email: _____
Address: _____ City/State/Zip: _____
Secondary Contact: _____ Phone: _____

Medical Information

Do you keep a log of your child's seizure activity? ☐ Yes ☐ No

Do you keep a log of rescue/emergency medication administration? ☐ Yes ☐ No

Date the student was diagnosed with seizures or epilepsy? _____

***Parent will need to notify school administrator or school nurse the next day if emergency anti-seizure medication, new medication or Over-the-counter medication is given outside of school hours.**

List all medications (given at home and school if more please discuss with nurse):

Medication Name ** Physician order if to be given at school	Dosage	Will this medication be given during school hours?	Frequency and scheduled time	Possible side effects

Use separate sheet if needed to answer questions.

Please describe seizure, length, frequency and how student presents after seizure activity. _____

Are there any warnings and/or behavioral changes before the seizure occurs? _____

What might trigger a seizure in your child? _____

When was your child's last seizure, and what type of seizure was it? _____

Have there been any changes in the seizure patterns for your child? If yes, please explain the changes. If no changes, please write "No". _____

How do other illnesses affect your child's seizure condition? _____

Have you administered rescue medication in past? If yes, please describe situation. _____

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HEALTHCARE PROVIDER - Please complete the information below and sign.

Invalid if altered by anyone other than child's provider.

Date started: _____ Date to be discontinued: _____

Rescue Medication

****If Rescue medication is administered, emergency medical services and parents will be contacted.**

****Only School Nurse or Trained School Personnel that are CPR certified can administer rescue seizure medication.**

☐ **No Seizure Medication at School:**

Child has not had a seizure requiring medication in the past 6 months, no emergency medication is required at school.

Nurse will call 911 and parent if child has:

- ✓ Convulsive seizure lasting more than _____ minutes.
- ✓ Repeated seizure without regaining consciousness.
- ✓ More seizures than usual or change in type of seizure

☐ **PRN Seizure rescue medication:**

If seizure last longer than _____ minutes administer medication below.

☐ Rectal Diazepam ☐ Nasal Midazolam ☐ Nasal Diazepam Dose: _____

Other Medication: _____ Dose _____ Route _____

Please describe seizure type and symptoms that require Rescue medication administration: _____

Contraindications for Rescue Medicine _____

VNS (If Applicable)

Do you recommend the magnet be kept "on person" by the student? ☐ NO ☐ YES Location of magnet: _____

Does the student understand the proper use of his/her VNS and can perform this procedure without assistance? ☐ Yes ☐ No

How to use and Frequency: ☐ Immediately ☐ within _____ min; if seizure continues, repeat after _____ min _____ times

Give emergency medication after _____ min and call 911

Special Instructions: _____

Healthcare Provider Name/Title

Healthcare Provider Signature

Date

Phone Number

Fax number

Email

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse or trained school personnel has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the healthcare provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Johnson City School System, the undersigned parent or guardian hereby understands and agrees that the Johnson City School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication. I, the undersigned parent or guardian hereby understand and agree that Johnson City Schools and its personnel shall not be liable for any injury resulting from the student's self-administration of the VNS, if applicable per health care provider's selection above, while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct. I will notify extra-curricular staff about the health plan and care to be given during after school activities, if applicable.

Parent/Guardian Signature

Printed Name

Date