



SEIZURE ACTION PLAN (SAP) 2026-2027 School Year

Name _____ Birth Date _____

Address _____ Phone _____

Emergency Contact/Relationship _____ Phone _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

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 _____

Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

Emergency Department: _____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (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: _____

Permission to Self-Carry/Self-administered

Student has permission to self-carry / self-administer this medication No Yes – if yes, read the following carefully:

If yes box is checked, I agree that this student must be allowed to have the above-named medication/procedure on his/her person during school hours, in transit to and from school or school-sponsored activities, before and after-school activities on school property, and any school sponsored activity. **This child has demonstrated competency in self-monitoring and self-administration of this medication/procedure.** The parent is aware that they cannot hold the school district responsible for any adverse outcome of this action.

Printed Name of Health Care Provider: _____ Phone: _____

Health Care Provider Signature: _____ **Date:** _____

Healthcare contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

Parents / Legal Guardians Please Read Carefully: *By signing below, I understand and agree to the following:*

- An Individualized Healthcare Plan (IHP) will be developed for students who have a health condition that necessitates an IHP.
- the school district and its employees and agents are not liable for an injury arising from a student's self-monitoring or self-administration of medication.
- the parent or guardian indemnifies and holds harmless the district and its employees and agents against a claim arising from a student's self-monitoring or self-administration of medication;
- the school district and its employees and agents are not liable for an injury arising from the administration of medication authorized by an IHP;
- the parent or guardian shall indemnify and hold harmless the district and its employees and agents against a claim arising from administration of medication authorized by an IHP.
- I understand that all prescribed medications must be in the original container issued by the pharmacist with the most recent prescription label.
- I will notify the school when the medication is discontinued or the dosage changes.
- I give permission for the principal, school nurse(s), and/or health services to share this information with individuals who have responsibility for my child.
- I give BCSD Health Services my permission to contact the prescribing Licensed Health Care Provider and prescribing pharmacy in relation to this prescription medication.
- I agree to allow my child's medication to accompany the teacher/staff on field trips if medication time coincides with the trip.
- I am responsible for replacing medication before the expiration date.
- I give my permission for designated BCSD staff to administer this medication to my child according to district requirements
- I understand that my child will lose the privilege to self-medicate if he or she endangers him- or herself or another student by misusing the medication(s).

Parent signature _____ Date _____

Provider signature _____ Date _____

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