

SEIZURE ACTION PLAN (SAP)



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END EPILEPSY

Name: _____ Birth Date: _____
Address: _____ Phone: _____
Parent/Guardian: _____ Phone: _____
Emergency Contact/Relationship: _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☒

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse 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 _____

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Name of Med/Rx _____ How much to give (dose) _____
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Care after seizure

What type of help is needed? (describe) _____

When is student 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: _____

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

See Back Page

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 2nd or 3rd 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:

- | | |
|---|--|
| ☐ General health _____ | ☐ Physical education (gym/sports) _____ |
| ☐ Physical functioning _____ | ☐ Recess _____ |
| ☐ Learning _____ | ☐ Field trips _____ |
| ☐ Behavior _____ | ☐ Bus transportation _____ |
| ☐ Mood/coping _____ | ☐ 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 _____

FORM A
Medication Administration Form
SEIZURES

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PERRY COUNTY SCHOOL DISTRICT

PARENT AUTHORIZATION AND INDEMNITY AGREEMENT/MEDICATIONS RELEASE:

The undersigned parent/s or guardian/s of _____, a minor child, has requested personnel(s) of the Perry County School District to administer the prescribed medicine by a physician to this student. This request has been made for my/our convenience as a substitute for parental administration of this medicine. It is understood that school administration will designate a school personnel(s) (who will not need a medical or nursing licenses), or school nurse to assist/ observe my child taking the prescribed medicine ordered by a physician. I/We forever release, discharge and covenant to hold harmless the school district, its personnel and board of trustees from any claims, demands, damages, expenses, loss of services and cause of action belonging to the minor child or to the undersigned arising out of or on account of any injury, sickness, disability, loss or damages of any kind resulting from the administration of the prescription medicine. The undersigned agree to repay the school district, its personnel or trustees any sum of money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any action or on account of any injury to the minor child as a result of the administration of medicine. I have read the foregoing release and indemnity agreement and fully understand it. Executed this the _____ day of _____, 20____.

Signature of Parent/Guardian

Witness

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: _____ DOB/Age _____ M/F

School _____ Grade _____ Teacher _____ School year _____

HT _____ WT _____ Allergies/Reactions _____

I request my child name and identified above to receive:

_____ Medication as prescribed by our physician on the form below or as listed on the container issued by the pharmacy.

_____ Non-prescription/over-the-counter medication provided by me along with Dr.'s order

I understand and consent to the release of the information to all school personnel(s) and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I consent to communication between the prescribing physician, the Pharmacist, & the school nurse for the management and administration of medications pertaining to my child's medical condition.

I authorize the school administration to designate a school personnel(s) (who will not need a medical or nursing licenses), or school nurse to assist/ observe my child taking the listed medication below. I understand that Perry County school district is rendering a service and does not assume any responsibility for this matter.

Name of Medication _____

Signature of Parent/guardian _____ **Date** _____ **phone#** _____

Emergency Contacts: Name: _____ **Phone#** _____

PRESCRIBER AUTHORIZATION (To be filled out by the Dr. or HCP)

StudentName: _____ DOB _____ Allergies: _____

Name of Medication _____ Strength [# milligrams(MG)] _____

Dosage [# of pills to take/ liquid to take] _____ Route: _____

Frequency (Time to be given at school) _____

Date to begin medication: _____ Date to stop med _____

Reason for taking the medication: _____

Potential side effects/adversereactions: _____

Any special instructions or Recommendations: _____

Health Care Provider Signature: _____ **Name:** _____

Date: _____ **Phone** _____

Parent to fill out back page see (Page 4)

**Perry County School District
Individualized Health Care Plan
Seizures**

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PARENT NEED TO FILL OUT THIS FORM:

Student Name: _____ DOB/Grade: _____

Homeroom Teacher: _____ Diagnoses: SEIZURES

Nursing Diagnosis (ND)	Nursing Intervention	Nursing goals/outcomes
1. Potential for injury r/t uncontrolled movements of sz activity. Student has hx of sz.	*Monitor for sz activity & tx as per MD order. * Have sz action plan on file. * If sz activity follow the below: Follow action plan & MD order, Stay with the student & stay calm, Call 911 and parents, monitor the date, time, duration of sz. Don't restrain student, don't put anything in mouth, stay with student at all times, protect head, keep airway open, turn on side, first aid care as needed.	*Student will not experience an injury during a sz. *Student will maintain healthy and well-being necessary for learning and action plan will be on file.

List Seizure type: _____. How long does it last: _____

How often does it happen: _____

Description: _____

List seizure triggers or warning signs: _____

Student reaction to seizure: _____

I _____ (parent/guardian) authorize for the school administration to designate a school personnel(s) (who will not need a medical or nursing licenses) &/or school nurse to assist /observe my child taking the prescribed medication which is (Name of medication) _____ and to perform and carry out the care as outlined in (student's name) _____ Individualized Healthcare Plan. I also consent to the release of the information contained in this Individualized Healthcare Plan to all school personnel(s) and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I consent to communication between the prescribing health care provider, the school nurse, and the designated school personnel(s) (which is assigned by the school administration) necessary for the management and administration of medications pertaining to my child's medical condition addressed on this Individualized Healthcare Plan

Parent/guardian Signature: _____ **Date** _____ **Phone#** _____

Emergency Contacts: 1. Name: _____ Phone # _____

2. Name: _____ Phone# _____