



Anchorage School District

Seizure Care Plan



Student:	DOB:	Grade:	Student ID:
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Hx of Condition

Seizure Type(s)	Frequency	Duration	Description of What Happens
Triggers or Warning Signs			
☐ Stress ☐ Lack of sleep ☐ Intense emotions ☐ Boredom ☐ Bright screens ☐ Fever ☐ Flashing lights ☐ Bright lights ☐ Other _____			
Child's Response Following Seizure			
Daily Seizure Medication Name, Dose, Time			
Other Information/Considerations <i>(surgery, devices, diet, allergies, other medical hx)</i>			

Immediate Seizure Interventions

☐ STAY calm and begin timing seizure ☐ Keep student SAFE – remove harmful objects, don't restrain, protect head ☐ Turn on SIDE if not awake, keep airway clear, don't put objects in mouth ☐ STAY with student until recovered ☐ Swipe magnet for VNS ☐ Write down what happens ☐ Refer to Emergency Medications on next page	WHEN TO CALL PROVIDER ☐ Change in seizure type, number or pattern ☐ The student does not return to usual behavior (i.e., remains confused for 30-60 minutes) ☐ First time seizure that stops on its' own WHEN TO CALL 911 ☐ Seizure with LOC longer than 5 minutes and not responding to rescue meds if available. ☐ Repeated seizures last longer than 10 minutes, no recovery between them, and not responding to rescue meds if available. ☐ Difficulty breathing after seizure ☐ Serious injury occurs or suspected ☐ Seizure in water (pool, lake, etc)
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Ordering Provider:	NPI:	Phone:
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Emergency Medication(s)

Medication	Dose	Route	Frequency	Indication (cluster, number, or length)
☐ Diazepam				
☐ Midazolam				
☐				

After Seizure Interventions

What type of help is needed?

When is student able to resume usual activity?

Ordering Provider:	NPI:	Phone:
Signature:	Date:	

Parent/Guardian Authorization

I request that the medication(s) selected above and seizure protocols listed on this plan be provided to my child. In the absence of the nurse, I expressly authorize other trained Anchorage School District ("ASD") personnel to administer this medication. I will provide needed medications or supplies for care in school. Prescription medication must be in the original pharmacy container labeled with the following information: name, medication, dosage, route, administration time, ordering healthcare provider, pharmacy, date issued, and prescription number. I understand that, in the absence of the nurse, other trained Anchorage School District ("ASD") personnel may administer this medication.

Employees and agents of ASD strive to provide treatment consistent with the appropriate standard of care but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the way it is administered, including for NEGLIGENCE. I will notify ASD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and ASD as part of the provision of my child's care. I agree for the nurse to share health information with ASD staff on a need-to-know basis for my child's safety and to foster academic success. I understand that ANY remaining medication(s) will be disposed of at the end of the school year, unless I pick up the remaining medication(s) by the last school day, as indicated on the ASD school year calendar.

Notify me when my child has seizures ☐ Every time ☐ Provider called ☐ 911 called

Name:	Phone:
Signature:	Date:

This authorization expires at the end of the current school year.