EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

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

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

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

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COMMUNITY UNIT SCHOOL DISTRICT 300
AUTHORIZATION FOR THE
ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name:_____ Date of Birth:_____

Address:_____

School _____Grade:_____

I hereby confirm my primary responsibility to administer medication to my child. However, in the event that I am unable to do so, I hereby authorize Community Unit School District 300 and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described. **I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATIONS TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A CERTIFIED SCHOOL NURSE AND SPECIFICIALLY CONSENT TO SUCH PRACTICES.** I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

For parent(s)/guardian(s) of students who Self-Administer Asthma Medications or may use an Epinephrine Auto-Injector for Anaphylaxis:
I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her medication (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication (105 ILCS 5/22-30). Beginning fall 2010 a physician's signature is not required for Asthma Inhalers and Epinephrine Auto-Injectors if the health office has a copy of the pharmacy labeled container for the medication(s). *If you agree please initial*: _____
_____

Parent(s)/Guardian(s) Signature:_____Date:_____

Phone: Home:_____ Work:_____Cell:_____

PHYSICIAN'S ORDERS (to be completed by student's physician)

Medication:_____

Dosage:_____Frequency:_____Administration Time:_____

Diagnosis Requiring Medication:_____

Possible Side Effects:_____

Special Instructions:_____

Signature:_____Date of Signature:_____

Physician's Printed Name:_____

Office Address:_____

Office Phone:_____ Fax Number:_____

COMMUNITY UNIT SCHOOL DISTRICT NO. 300
PROVIDER'S ORDER FOR THE ADMINISTRATION
OF DIASTAT IN THE SCHOOL SETTING

Student's Name:_____ **D.O.B.**_____

Medical Diagnosis:_____ **ICD-9 Code:**_____

Treatment:

• DIASTAT® (diazepam rectal gel)_____ mg rectally as needed for:_____
seizures lasting greater than _____minutes OR for _____or more seizures in _____hours

• Use VNS (vagal nerve stimulator) magnet_____

• Other_____

• Call 911 if DIASTAT is given

• Parents/caregiver should be notified immediately

• Let EMS Personnel know if:

- Seizure does not stop by itself or with VNS within _____ minutes
- Seizure does not stop within _____ minutes of giving DIASTAT or if 1st dose of DIASTAT ever received
- Child does not start waking up within _____ minutes after seizure is over (no DIASTAT given)
- Child does not start waking up within _____ minutes after seizure is over (after DIASTAT given)

Following a seizure:

☐ Child should rest in nurse's office

☐ Child may return to class (if DIASTAT was NOT given)

☐ Parents/caregiver should receive a note/copy of the seizure record sent home with the child

• What side effects can be expected after the administration of DIASTAT?_____

_____

• What was the child's response to the first dose of DIASTAT?_____

_____

• What action should be taken if the child has a bowel movement or expels the medication?_____

_____

• If the child has a cold, respiratory infection or fever, should the DIASTAT be given?_____

• **If a seizure should occur while the child is being transported on the school bus, on a field trip or at a community based instruction site, our procedure would be to call 911. Any additional comments?**

_____

Physician/Nurse Practitioner/Physician's Assistant Name (Printed) _____

Signature _____ Date _____

Address _____Phone _____

Parent/Guardian Signature_____Date_____

COMMUNITY UNIT SCHOOL DISTRICT 300
PROCEDURE FOR ADMINISTRATION OF MEDICATION

Prior to the District's administration of any medication, the District shall have on file a medication program for the involved student prepared by the student's attending licensed prescriber in compliance with CUSD #300 procedures and signed by the student's parent/guardian.

Whenever possible, the parent/guardian should make arrangements for medication to be administered at home, before and/or after school hours. In situations when a student's health could be compromised by not receiving medication during school hours, school district policy and procedures must be followed for administering all medications.

1. Medication is defined as prescription or non-prescription (over the counter) drugs, including vitamins and supplements.

2. Administration of **any** medication requires both a physician's written order and signed parental permission. ***Beginning fall 2010 a physician's signature is not required for Asthma Inhalers and Epinephrine Auto-Injectors if the health office has a copy of the pharmacy labeled container for the medication(s).***

3. Prescription medication must be in a pharmacy or physician labeled container. Over the counter medication must be brought in with the original manufacturers label, clearly marked with the student's name.

4. It is the parent's/guardian's responsibility to bring the medication to school.

5. All medications to be taken during school hours will be kept in the nurse's office. It is the responsibility of the student to report to the nurse's office at the proper time to receive his/her medication. Students are allowed to carry and self-administer asthma medication or may use an Epinephrine Auto-Injector for anaphylaxis only after the school is notified and the student's parent/guardian and physician have signed the appropriate authorization form.

6. The parent/guardian must assume responsibility for informing the school (in writing) of any change in the student's health or change in medication. A physician's order must accompany any medication change.

7. Medication must be picked up by a parent/guardian on or before the last day of school. Medication not picked up will be discarded.

8. The school district will reject requests for administration of medication if it does not receive all of the required information on the authorization form.