

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: _____

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

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 _____

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 **Can the student self-carry medication(s)?** 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 _____



STUDENT MEDICATION REQUEST FORM

This form must be completed in full and returned with a physician's signature to current school office before administration of medication can take place within the school. OTC medications also require a physician's signature.

Student Name & DOB:	School & Grade:
Parent/Guardian:	Phone:
Parent/Guardian:	Phone:
Name of Prescription or OTC Medication:	
Form of Medication (circle one): Tablet/Capsule Liquid Inhaler Medi-pen Other: _____	
Time to be administered:	
Is this medication for episodic or emergency events only? (circle one):	Yes No
Is the student able to self-carry this medication? (circle one):	Yes No
Possible side effects from medication:	
Health Care Provider Signature:	Phone:
Printed Name:	
Preferred Hospital:	Fax:
Emergency Contact:	Phone:

I give permission for school personnel to share this information, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and equipment devices. I understand and agree that when school personnel administer medication to my child as indicated above, I will not hold the personnel and school district liable in any criminal action or for civil damages. Reference: Act #157, Public Acts of 1971, effective 11/24/1971, Section 378.

All medications must be collected by a parent or guardian within one week of the last day of classes for students. Any medications left after that time will be properly disposed of.

Parent Signature

Date

School Office Use Only	Administration Office Use Only
Date Received:	Date Received from Building:
Location of Medication:	Date Recorded:
Reminder: Scan/Email to School Nurse & Administration Office	Reminder: Set Alert in PowerSchool, Upload to CEO