SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply) ☑

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

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: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

Epilepsy.com

Revised 01/2020 130SRP/PAB1216

EPILEPSY FOUNDATION | END EPILEPSY

Waverly Community Schools Medication Administration Authorization Form

Michigan State Law requires that school staff administering medications must have written orders from the physician/licensed prescriber and written authorization from the parent/guardian**.**
Parents are urged to give medication at home on a schedule outside of school hours, if possible. If it is necessary that medication be provided during school hours, these regulations must be followed:

- All prescription medications must have a written order from a physician or other licensed prescriber and must be renewed every year or with any changes. Any medication that is a controlled substance must be renewed every 30 days or with any changes.
- All medication must be brought to school in the original pharmacy or OTC container labeled with the name of the student, medication, strength, dosage, route, and time(s) to be given. The parent/guardian is expected to deliver the medication to the school. Students are not allowed to bring their own medication to school.
- Medications and related equipment/supplies, as ordered, must be provided to the school by parent/guardian as needed.
- A separate authorization form must be completed for each medication that will be administered throughout the school day.

STUDENT'S NAME: _____ DATE OF BIRTH: _____

SCHOOL:_____

TO BE COMPLETED BY THE PHYSICIAN:

Medication Name	Dosage	Route	Frequency and Time

Form of Medication: ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Other:	
Diagnosis:	
Special instructions/storage requirements:	
Restrictions and/or important side effects:	
Is student able to self-carry this medication? ☐ Yes ☐ No	
Order start date:	**Order end date:**
(If no end date is indicated, medication orders will expire at the end of the current school year).	
Prescriber signature:	**Date:**
Printed Name:	**NPI#:**
Address:	
Phone:	**Fax:**

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby give permission for school personnel to exchange this information as necessary, administer medication, and provide care for my child, and to contact the child's physician when deemed necessary. I assume full responsibility for providing the school with all prescribed medications as outlined above and any required medical equipment or devices.

I understand and agree that, pursuant to Public Act 157 of 1971 (MCL 380.1178), when school personnel administer medication to my child in accordance with this authorization, I shall not hold the school district, its employees, or agents liable in any criminal action or for civil damages resulting from the administration of such medication, except as provided by law.

All medications must be picked up by a parent or legal guardian within one (1) week following the student's last day of classes. Any medication not collected within this timeframe will be disposed of in accordance with applicable laws and school district policy.

Signature:	Relationship:	Date:

Please return completed form to the school office or to the District Nurse

Revised 01/21/2026