SEIZURE ACTION PLAN FOR SCHOOL

Student Name_____ D.O.B._____
School_____ Teacher_____
Physician_____ Phone_____

EMERGENCY CONTACTS
Name Relationship Home # Work # Cell #
1._____
_____
2._____
_____
3._____
_____

Type of seizure :_____

What does the seizure look like and how long does it usually last?
_____
_____
_____
Possible triggers that should be avoided: _____

Does student need any special activity adaptations/protective equipment (e.g., helmet) at school?
_____ No _____ Yes (explain) _____
_____

Is student allowed to participate in physical education and other activities? _____ No _____ Yes
List any activity limitations_____
_____

ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES? _____ No _____ Yes
MEDICATIONS-AMOUNT TAKEN-HOW OFTEN
1._____
2._____
3._____

List medication needed at school (name, dosage/route, and frequency)
_____
_____

IF GENERALIZED SEIZURE OCCURS: STAY CALM!
1. If falling, assist student to floor, turn to side.
2. Loosen clothing at neck and waist; protect head from injury.
3. Clear away furniture and other objects from area.
4. Have another classroom adult direct students away from area.

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:_____

Treating Physician:_____ Phone: _____

Significant medical history:_____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:_____

Student's reaction to 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 (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

EMERGENCY RESPONSE:

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

A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

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

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

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use_____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

Physician Signature:_____ **Date:**_____

Parent Signature:_____ **Date:**_____

To be filed at the student's school building

Student's Name: _____ DOB: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

School: _____ Grade: _____ Teacher: _____

To be completed by the student's physician:

Name of Medication: _____ Dosage: _____ Frequency: _____

Time to be given at school: _____ Date of prescription: _____ Date of order: _____ Discontinuation date: _____

Diagnosis requiring medication: _____ Intended effect of medication: _____

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition: Yes: ☐ No: ☐ Expected side effects, if any: _____

☐ The medication above is to be self-administered. I certify that the student named above has been instructed in the use and self-administration of the above named medication and the child can fulfill the requirements of the procedure.

☐ The above student may carry the prescribed medication and / or inhaler.

Other medications student is receiving: _____

Physician's Signature: _____ Date: _____ Physician's Name: (please print) _____

Physician's address: _____ Phone: _____ Emergency Phone: _____

I confirm that I am primarily responsible for the administering of medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Alton Community Unit School District #11 and its employee's 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 employee's and agents of the School District) lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. The School Nurse caring for my child may communicate with the prescribed physician regarding medications or health issues relating to this medication. 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, it's employee's and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, it's employee's and agents, either jointly or separately, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

☐ If your child has asthma, I understand, in accordance with the new Asthma Action Plan Law, an Asthma Action Plan MUST be provided to the school for all student's with Asthma. Please request an Asthma Action Plan from your doctor. The inhaler should be brought to school with the Asthma Action Plan and the medication authorization form and given to the nurse for review.

_____
Parent(s) / Guardian (s) Name (Please Print)

_____
Parent(s) / Guardian(s) Signature

_____
Date

Alton Community Unit School District #11
Alton, Illinois

Date_____

Dear Parent(s)

Alton Community Unit School District No 11 guidelines for the administration of medication include the following requirements:

1. No non-prescription medication will be administered at school.
2. ONLY MEDICATION THAT IS ABSOLUTELY NECESSARY FOR THE CRITICAL HEALTH AND WELL BEING OF THE STUDENT WILL BE ADMINISTERED AT SCHOOL.
3. The school nurse must receive a written statement form the student's physician stating that the medication is absolutely necessary for the critical health and well being of the student.
4. The student's physician must also provide the school nurse a written order detailing:
   a. the necessity for the medication during the day,
   b. the type of disease or illness involved,
   c. the benefits of the medication,
   d. the side effects,
   e. the name of the drug, dosage, and the time interval in which the medication is to be taken,
   f. and an emergency number where he/she can be reached.
5. A NEW "MEDICATION AUTHORIZATION" FORM MUST BE SUBMITTED EACH SCHOOL YEAR. WE WILL NOT ACCEPT COPIES OF FORMS FROM PRIOR YEARS. ANY CHANGE IN MEDICATION OR DOSAGE WILL ALSO REQUIRE A NEW FORM.
6. All approved medication must meet the above requirements. Such approved medication must be brought in a container appropriately labeled by the physician or pharmacist. The parent or guardian must bring the medicine to school to avoid unsupervised transportation.
7. Parents are to use the School Medication Authorization Form (MN-24) for school administration of medication and the parent/guardian signature is required.
8. Students known to be allergic to "BEE" or other insect stings that may require emergency administration of medication and/or transportation to the hospital should have the Injectible Medication Authorization Form (MN-24c) completed and on file. You may get MN-24c from the school nurse or school principal.

Sincerely,

Student Health Services Director