



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: _____

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 _____

- 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

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: _____

Charter School of Excellence
Authorization for Medication to be taken during School Hours

I request that my child _____, Date of Birth _____, Grade _____, be assisted in taking medications described below at school by authorized persons. I understand that I am responsible for submitting the medication in a proper and timely manner and that, if necessary, the school may request additional information from the physician regarding this medication. I agree to abide by the medication policy and I understand that this form must be renewed annually and anytime there is a change in drug, time or dose.

I agree to waive the School District, their officers, representatives and employees of liability, claims, demands, and causes of action arising out of or in any way connected with the giving of the prescribed medication or treatment. The undersigned parent or guardian hereby assumes all risk of injury or damage to the minor child receiving prescribed medication or treatment during school activities, and specifically waives any claims for acts of negligence by employees of the School District.

Furthermore, as a parent or guardian of the minor child to receive prescribed medication and/or treatment, the undersigned hereby expressly agrees to indemnify and forever hold harmless the Charter School of Excellence, officers, and their employees against loss or any claims, demands, causes of action that might be brought by the minor or in his/her behalf to defray the damages incurred by the taking of the prescribed medication and/or treatment given by the School District during regularly scheduled school hours or activities in the School District. As parent or guardian, I hereby waive all exemption rights under all state laws against any claims for reimbursement or indemnification.

Name of medication to be given at school: _____

Other medications student is taking: _____

Allergies: _____

Parent/Guardian Signature

Date

Emergency Contact

The Physician Completes the Following Section:

Name of medication to be given at school: _____

Diagnosis for which the medication is given: _____

Dosage: _____ Time(s): _____ Route: _____

Significant side effects: _____

Dates Medication to be given from: _____ to _____

Can this medication be adjusted to accommodate class schedule: yes or no

If yes, by how much time? _____

Other information: _____

Printed Physician Name

Physician Phone Number and Fax Number

Physician Signature

5/2010