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:**_____

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Questionnaire for Parent of Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Contact Information

Student's Name | School Year | Date of Birth

School | Grade | Classroom

Parent/Guardian | Phone | Work | Cell

Parent/Guardian Email

Other Emergency Contact | Phone | Work | Cell

Child's Neurologist | Phone | Location

Child's Primary Care Doctor | Phone | Location

Significant medical history or conditions

Seizure Information

1. When was your child diagnosed with siezures or epilepsy? _____
2. Seizure type(s)

Seizure Type	Length	Frequency	Description

3. What might trigger a seizure in your child? _____
4. Are there any warnings and/or behavior changes before the seizure occurs? ❒ YES ❒ NO
   If YES, please explain: _____
5. When was your child's last seizure? _____
6. Has there been any recent change in your child's seizure patterns? ❒ YES ❒ NO
   If YES, please explain: _____
7. How does your child react after a seizure is over? _____
8. How do other illnesses affect your child's seizure control? _____

Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? ❒ YES ❒ NO
    If YES, what process would you recommend for returning your child 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

Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? ❒ YES ❒ NO
    If YES, please explain:

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 diabetic
- ❒ Student has a first-time seizure
- ❒ Student has breathing difficulties
- ❒ Student has a seizure in water

Seizure Medication and Treatment Information

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and time of day taken	Possible Side Effects

14. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to do after administration

* After 2nd or 3rd seizure, for cluster of seizure, etc. ** Orally, under tongue, rectally, etc.

15. What medication(s) will your child need to take during school hours? _____
16. Should any of these medications be administered in a special way? ❒ YES ❒ NO
    If YES, please explain: _____
17. Should any particular reaction be watched for? ❒ YES ❒ NO
    If YES, please explain: _____
18. What should be done when your child misses a dose? _____
19. Should the school have backup medication available to give your child for missed dose? ❒ YES ❒ NO
20. Do you wish to be called before backup medication is given for a missed dose? ❒ YES ❒ NO
21. Does your child have a Vagus Nerve Stimulator? ❒ YES ❒ NO
    If YES, please describe instructions for appropriate magnet use:

Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

❒ General health _____ ❒ Physical education (gym/sports) _____
❒ Physical functioning _____ ❒ Recess _____
❒ Learning _____ ❒ Field trips _____
❒ Behavior _____ ❒ Bus transportation _____
❒ Mood/coping _____ ❒ Other _____

General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? _____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ❒ YES ❒ NO

Dates _____
Updated _____

Parent/Guardian Signature _____ **Date** _____

ARCHDIOCESE OF ATLANTA

MEDICATION PERMIT FORM

All medication should be given outside of school hours if possible. Three-times-a-day medications should be given before school, after school and at bedtime for optimal coverage. If necessary, medication can be given at school only under the following conditions:

1. If medication is needed in order for the student to remain in school, this form must be completed by the parent/guardian, signed by the physician, and returned with the medication to the school office or nurse.

2. All necessary medication prescribed for a student by a doctor or dentist must have this Medication Permit Form signed by the physician and parent. All prescription medication must be in the prescription bottle and labeled with a current pharmacy prescription label. "Over the counter" medication must be in original labeled container. Medications sent in baggies or unlabeled containers will not be given.

3. The **parent** is responsible to bring all medication to the clinic/office and to pick up unused medicine or it will be destroyed.

4. Experimental medication/dosages will not be given. Herbal medication, dietary supplements and other nutritional aids not approved as medication by the FDA, will not be administered at school.

5. Antibiotics will not be given at school by school personnel. If the parent feels the antibiotic must be given during the school day, the parent may come to the school office/clinic and administer it.

6. All medications must be kept in a locked cabinet/drawer in the school office/clinic and administered in the school office/clinic.

7. **High School** students whose doctor's written instructions require them to carry an inhaler on their person may do so. A second inhaler must also be kept in the clinic for use as needed. If a student allows another person to use the inhaler, the privilege of carrying one's inhaler may be revoked for both parties involved. Only those students in High School may transport their medication from home to the school office/clinic, and return unused medication home.

8. Only the **parent or adult designee** perform nebulizer treatments in school.

TO THE NURSE OR HEALTH REPRESENTATIVE OF: ST. PIUS X CATHOLIC HIGH SCHOOL

NAME OF STUDENT:_____ GRADE:____ ROOM:____

NAME OF MEDICATION:_____

DOSAGE AND DIRECTIONS FOR GIVING:_____

BEGINNING DATE:_____ ENDING DATE:_____

I hereby request that the medication specified above be given to the above named student, and that the medication may be given by someone other than a medically trained person.

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Atlanta, its servants, agents, and employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Atlanta, its agents, servants, or employees, including, but not limited to the parish (if applicable), the school, the principal, and the individual giving or failing to give the medication.

SIGNATURE OF PARENT/GUARDIAN:_____ DATE:_____

SIGNATURE OF PHYSICIAN:_____ DATE:_____
(STAMPED SIGNATURE NOT ACCEPTED)

PHYSICIAN'S TELEPHONE NUMBER:_____