Seizure Action Plan

Student's Name | Date of Birth | Grade | Teacher

Parent/Guardian | Phone | cell

Emergency Contact | Phone | cell

Treating Physician | Phone

Significant medical history

Seizure Information

Seizure Type	Length	Frequency	Decription

Seizure triggers or warning signs/ Student's reaction to seizure(s):

Date of last 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

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 _____

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 log

Tonic-clonic (grand mal) seizure:

☐ Protect head
☐Keep airway open/watch breathing
☐ Turn child on side

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 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. ✓	**Name of Med.**	**Dosage & Time of Day Given**	**Common Side Effects & Special Instructions**

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Physician's Signature _____ Date _____
Parent/Guardian's Signature _____ Date _____

Name _____

Grade _____ Teacher _____

Permission for Self-Administration of Medication
For Field Trips

The Selinsgrove Area School District understands overnight/extended trips or trips where the school nurse is unable to attend may require a student to self-administer a medication. All medications, over-the-counter and prescription must be kept in the original labeled container. The student, parent/guardian, and physicians must each sign this form and return it to the school nurse.
The following conditions must be met before a child may be considered for this exceptional practice:

- Student understands the purpose of his/her medication
- Student understands the responsibilities for self-administration of the medication
- Student has a knowledge of what could happen if the medication were improperly administered
- Student is technically capable of self-administering the medication

The following signatures certify that each party agrees that the child has met each of the aforementioned conditions and is capable of accomplishing self-medicating.

Student: _____ Date: _____

Parent/Guardian: _____ Date: _____

Physician Signature: _____ Date: _____

Medication Information

Name of Medication	Dosage of Medication	Frequency of Medication	Times for Self-Administration

All medications sent on overnight/extended trips should be supplied by the parent/guardian unless other arrangements are made with the school nurse (such as medications sent in to the school to be administered during school hours).

CHILD AND PARENT CONSENT

I, _____, agree to take the exact amount of my medication at the aforementioned time(s).

Furthermore, I, _____, agree that I understand the importance of taking medication(s) as prescribed and not give the medication to anyone else.

We agree that it is the child's and the child's parents responsibility that the medication(s) be administered properly; that the child will carry on his/her person the agreed upon amount of medication in an appropriate container identifying the child's name and medication contained; that if there is a diversion with the medication, the child will be disqualified from this exceptional procedure; and, if there is theft or intimidation with the intent of theft of a medication, appropriate action will be taken by the parents in conjunction with the school, including appropriate legal action.

I relieve and release the Selinsgrove Area Board of School Directors and its' employees of <u>all</u> liability related to the medication of my child.

<u>Child's signature:</u>

_____Date: _____

<u>Parent/Guardian signature:</u>

_____Date: _____

I have reviewed the above information on both pages and all the necessary signatures and information has been submitted.

<u>School Nurse or School Personnel Signature:</u>

_____Date: _____