EPILEPSY FOUNDATION

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 _____

Other Emergency Contact _____ Phone _____ Cell _____

Treating Physician _____ Phone _____

Significant Medical History _____

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a 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 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
- ☐ Administer emergency medications as indicated below
- ☐ Notify doctor
- ☐ Other _____

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 a 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. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ☐ Yes ☐ No If YES, describe magnet use:

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

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

DPC772

Daily/PRN

Attachment A

WASHINGTON TOWNSHIP PUBLIC SCHOOLS

REQUEST FOR PUPIL MEDICATION TO BE TAKEN AT SCHOOL

The administration of medication to or by any pupil will be permitted only when failure to take such medication would jeopardize the health of the pupil or the pupil would not be able to attend or benefit from his/her educational program. Medication includes all prescriptions and patent medications (over the counter). Washington Township Public Schools requires both physician and parent permission to administer all medication, including patent (over the counter) medication.

Note to Parent/Guardian: All medication(s) whether patent or prescribed shall be provided to the school nurse by the parent/guardian in the original container. In the case of prescription medication, the original container must have affixed the current prescription labeling as applied by the pharmacy.

Authorizations are effective for one school year only and must be renewed annually. All forms must be received and be on file in the school's Health Office before any medication can be administered.

SECTION A: Parent Request and Consent (To be completed by *Parent/Legal Guardian*)

PLEASE PRINT:

Pupil's Name: _____ School: _____

Parent's/Guardian's Name: _____

Address: _____

Home Phone #: _____ Parent's/Guardian's Work Phone: _____

PARENT'S CONSENT AND SIGNATURE

I, _____ (Name of Parent/Legal Guardian), request that my child, _____, be assisted in taking the medication(s) described above at school, as authorized by me and my physician.

_____ _____

Parent/Guardian Signature Date

See back of page for information to be completed by physician

SECTION B: Physician's Certification (To be completed by the *Physician*)

Physician: _____

Diagnosis for which medication is given: _____

Name of medicine: _____

Form (oral, injection): _____

Dose: _____

If given daily, at what time? _____

If given when needed, describe indications. _____

How soon can it be repeated? _____

Are there significant side effects? _____

Length of time this treatment will continue? _____

Other significant information: _____

_____

I certify that the above statements are true and that the pupil is physically fit to attend school and is free from contagious disease. He (she) would not be able to attend school if the medication is not administered during school hours.

_____ _____

Physician Signature Date

Affix physician's official stamp here:
