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

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

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Questionnaire for Parent of a 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 seizures 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 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 diabetes
- 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 functioning ____________________
❒ Learning ____________________
❒ Behavior ____________________
❒ Mood/coping ____________________
❒ Physical education (gym/sports) ____________________
❒ Recess ____________________
❒ Field trips ____________________
❒ Bus transportation ____________________
❒ 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** ______________

DPC776

LAKE PARK SCHOOL DISTRICT 108
DAILY & AS NEEDED MEDICATION AUTHORIZATION FORM

STUDENT NAME: ____ BIRTHDATE: ________________

CAMPUS: ________________ ID NUMBER: ______________ PHONE NUMBER: ________________

EMERGENCY CONTACT NAME: ____

TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

Our district policy and guidance from the Illinois State Board of Education states that all prescription and nonprescription medications that are given during the school hours must have this form completed prior to the administration of any medication. No medication will be given during the school day unless absolutely necessary for the critical health and wellbeing of the student. By signing below, I agree that I am primarily responsible for administering medication to my child. However, I authorize Lake Park High School District 108, and its employees and agents, on my behalf and in my stead, to administer medication to my child or to allow my child to self-administer medication while under the supervision of the employees and agents of the school district, lawfully prescribed medication in the manner listed above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than the school nurse and specifically consent to such practices. I also give my permission for Lake Park High School District 108 to share all pertinent medical information about my child with school staff members involved with my child. I further acknowledge and agree that when the lawfully prescribed medication is so administered, I waive any claims I might have against the school district, its employees and agents, arising out of said medication. In addition, I agree to indemnify and hold harmless the school district, its employees and agents, jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct.

All medications must be:

1) **In the original prescription container or original manufacturer's package if non-prescription;**
2) **Properly labeled with the name of the student, the prescribing physician, name of the medication, dosage, route, the time to be given, name of the pharmacy, and**
3) **Medication should be brought to school by the parent or other responsible adult. Controlled medications must be counted in the presence and with the signatures of the parent/guardian and two staff members.**

This medication from must be completed with the medication packaged properly as outlined above or the medication will not be given.

Name of medication, dosage, route & time: ____

Parent/Guardian Signature: ____ **Date:** ________________

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TO BE COMPLETED BY THE STUDENT'S LICENSED PRESCRIBER/PHYSICIAN

Student Name: ____ DOB: __________________

Name of Medication and Dosage: ____

Route and Time: ____

Time/Circumstances when medication should be administered: ____

Diagnosis/Reason for Medication: ____

Side Effects: ____

Other medications student is taking: ____

Start Date: ________________________ End Date: ______________________

______________________________ ____

Physician Phone Physician Print Name

______________________________ ____

Physician Address Physician Signature Date

Updated 1/9/19