Effective Date

_____

Seizure Action Plan

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Photo of Student Here

Student's Name _____

Date of Birth _____

Parent/Guardian

Phone _____

Cell _____

Other Emergency Contact

Phone _____

Cell _____

Treating Physician

Address _____

Phone _____

Significant Medical History

_____

_____

_____

_____

_____

_____

_____

_____

_____

SEIZURE INFORMATION:

○ Partial Seizures ○ General Seizures ○ Mixed

Seizure Type	Length of Time	Frequency	Description
Seizure Trigger Warning Signs		**Student's Response After Seizure**	

EMERGENCY RESPONSE

A "seizure emergency" for this student is defined as:

_____

_____

_____

_____

_____

_____

_____

_____

_____

SEIZURE ACTION 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 and track time
- Do not restrain
- Do not put anything in mouth
- Stay with student until fully conscious
- Record seizure on plan
- For Tonic-clonic (grand mal) seizure
- Protect head
- Keep airway open/watch breathing
- Turn student on side

A seizure is generally considered an emergency when:

- Convulsive seizure lasts longer than five 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 the water

TREATMENT PROTOCOL DURING SCHOOL HOURS

Emergency Medication	Dosage / How Often	Common Side Effects & Special Instructions

Additional Instructions:

List other medications taken at home:

Does student have a VAGUS NERVE STIMULATOR (VNS)? ● 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 _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the undersigned, authorize_____(Disclosing Institution) and its employees to release information from my medical records as described above to the school nurse. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department of the treating physician. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one (1) year from date of signature.

I understand that treatment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

As a professional courtesy, no cost is assessed for information released directly to your health care provider.

Revocation of this release still entitles me to all other rights of a student within the

_____ (School District).

Parent/Guardian Signature _____ Date _____

Student Signature (If Applicable) _____ Date _____

Description of Legal Representative's Authority to Act on Behalf of Student (if applicable):

_____