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:

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 _____

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

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

Guthrie Public Schools

Parental Authorization to Administer Medicine or Assist with Application of Sunscreen

TO: _____ _____

(Administrator) (School)

I am the parent, guardian or legal custodian with legal custody of _____, a minor student attending this school.

☐ This student requires medication (not including sunscreen) at intervals during the school day. I hereby give my consent and authorize the school nurse, the principal, or _____ (an employee of the School District designated by the school nurse, the principal, and me) to administer:

☐ (name of drug) _____, a non-prescription medication which I am hereby supplying you, in accordance with my written instructions or the written instructions of a physician which are attached hereto.

☐ (name of drug) _____, a filled prescription medication which I am hereby supplying you, in accordance with the directions for the administration of the medicine listed on the label of the vial.

☐ (name of drug) _____, a filled prescription medication which I am hereby supplying you, in accordance with the written instructions of the physician prescribing the medicine, which is attached hereto.

☐ I hereby give my consent and authorize my child to self-medicate under the School District's Policy on the Administration of Medicine to Students.

☐ I desire that the school assist the student in applying sunscreen. I understand that the student may possess and self-apply sunscreen without my written authorization. I hereby give my consent and authorize the school nurse, the principal, or _____ (an employee of the School District designated by the school nurse, the principal, and me) to assist the student in applying sunscreen:

☐ sunscreen, which I am hereby supplying you, in accordance with the label directions.

☐ sunscreen, which I am hereby supplying you, in accordance with written instructions of the student's physician which I have attached.

I understand that under state law the Board of Education, the School District, or employees of the School District shall not be liable to the student or the student's parent or guardian for civil damages for any personal injuries to the student which result from acts or omissions of school employees in administering the medicine or assisting in the application of sunscreen I have hereby authorized. I understand that the School District, its agents and employees shall incur no liability for any adverse reaction or injury suffered by the student as a result of the self-administration of medication and/or using the specialized equipment.

I agree to abide by all of the terms of the School District's Policy on the Administration of Medicine to Students, a copy of which will be given to me on my request.

_____ _____

Date Signature

_____ _____

Address Parent with legal custody/guardian

Guthrie Public Schools
MEDICATION AUTHORIZATION

Student: _____ **Birthdate:** _____ **Grade:** ____ **School:** _____

Parent/Guardian: _____ **Phone:** _____ **Date:** _____

PRESCRIPTIONS TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

- Reason for medication _____
- Name of medication _____
- Dosage _____
- Time and Route to be administered _____
- Duration (week, month, indefinite, etc.) _____
- Possible side effects _____

_____ _____ _____
Physician/Licensed Prescriber's Signature Office Phone Date

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN:

I hereby request and give my permission for the above-named school to administer the medication authorized on this form to my child. I understand that I am responsible for maintaining the supply and picking up any remaining medication at the end of the school year; medication will not be sent home with students. Medication remaining after the school year has ended will be discarded utilizing proper procedure. I give my permission to the school nurse/designated employee to consult with the prescriber regarding this prescription.

_____ _____
Parent/Guardian Signature Date

COMPLETE ONLY FOR SELF-ADMINISTRATION OF ASTHMA MEDICATION, ANAPHYLAXIS MEDICATION, OR REPLACEMENT PANCREATIC ENZYMES

TO BE COMPLETED BY PHYSICIAN/LICENSED PRESCRIBER:

- This student has been instructed in the proper use of his/her medication. It is my professional opinion that this child is both capable and responsible of self-administering this medication and shall be allowed to carry this medication on his/her person. Yes ☐ No ☐

_____ _____
Physician/Licensed Prescriber's Signature Date

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN:

I hereby give my consent and authorize my child to self-administer and/or self-carry his/her medication at school.
I will provide an emergency supply of this medication to be administered by school personnel, as required by State law.

_____ _____
Parent/Guardian Signature Date

I will not knowingly share my medication with another student.

_____ _____
Student Signature Date

It is Guthrie Public Schools policy that medication and sunscreen will only be administered by school staff with written authorization of the child's legal custodian and/or written instructions from the child's physician. Medication must be in the original container with proper labeling: child's name; medication name, strength, and expiration date; dosage and instructions for administration; name of licensed prescriber/physician; pharmacy name, address, and phone number. Authorization forms must be completed annually for each medication, and for any changes to dose/administration time. School staff will not administer medication or sunscreen that is not in the original container, improperly labeled, unauthorized, or expired. Medication must be brought to school by a parent/legal guardian.

Receiving Employee: _____ Date: _____