Seizure Action Plan

Monticello Public Schools Health Services

Instructions:

Physician: *Please complete this page*

Parent/Guardian: *Please complete Page 2 (back)*

Student: _____ DOB: _____ Grade/Teacher/School: ____/_____/____

Physician/Clinic/: _____/_____ Telephone/Fax#: _____/_____

TYPES OF SEIZURES

❑Absence ❑Simple partial seizures ❑Complex partial seizures ❑Drop (atonic) seizures
❑Generalized tonic-clonic seizures ❑Tonic seizures ❑Other (specify) _____

SEIZURE INFORMATION

- Date of last seizure:_____
- Describe typical seizure:_____
- Length of typical seizure:_____
- Frequency of seizures: ❑Daily ❑Weekly ❑Monthly ❑Other (specify):_____
- Possible triggers:_____
- Student's response following seizure:_____

FIRST AID PROCEDURE

1. Note time seizure begins.
2. Remove sharp or harmful objects around student to provide a safe environment.
3. Loosen tight clothing and turn student on side, if able.
4. Do not restrain student. Do not attempt to put anything in student's mouth.
5. Assure student that they will be fine. Stay with student until recovered. Allow to rest after seizure.
6. Document how long seizure lasted and report to parents or emergency personnel as needed.

EMERGENCY RESPONSE

- Administer emergency medications as indicated below, for seizure lasting greater than _____ minutes.
- Call 911 when: ❑ emergency medication(s) is/are administered or if student is having difficulty breathing
  ❑ seizure is longer than 5 minutes
  ❑ other(specify):_____

MEDICATIONS (Daily and Emergency)

✓ if emergency medication	Medication	Dosage & Time of Day Administered	Common Side Effects & Special Instructions

TYPES OF LIMITATIONS

❑No Limitations ❑Playground (specify:_____
❑Physical Education (specify):_____ ❑Other (specify):_____

PHYSICIAN AUTHORIZATION

I authorize the above plan to be followed in school.

Physician's Signature:_____ Printed Name of Physician:_____ Date:_____

Parent/Guardian to complete

Parent/Guardian:_____ H#:_____ W#:_____ C#:_____

Parent/Guardian:_____ H#:_____ W#:_____ C#:_____

Field Trips:

- Parent will be asked to attend field trips
- If supplied by parent, Diazepam (Diastat, Valium, etc...) will be sent along to be used by parent
- 911 will be called as needed

PARENT/GUARDIAN REQUEST FOR MEDICATION ADMINISTRATION

1. I request medications be given during school hours as ordered by my child's physician/licensed prescriber.
2. I release school personnel from liability in the event adverse reactions result from taking any of these medications.
3. I will notify the health office of changes in any of these medications (dosage, discontinued, etc...).
4. I give permission for health office staff to consult with the physician/licensed prescriber regarding any questions that arise with regard to these medications or medical conditions being treated by these medications.
5. I give permission for the medications to be administered by the designated personnel as delegated by the school nurse.
6. If your child has any remaining medications in the health office during or at the end of the school year, we would prefer to have you pick it up. Please indicate below which plan we are to follow. If you have any questions or concerns, please contact the health office.

❑**Plan A** (preferred): I will pick up my child's medications at school.

❑**Plan B**: Please leave the medication at school for the following school year.

Note: Medication must be supplied in the original prescription container.

PARENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for health office personnel to communicate, as needed, with school staff about my child's medical conditions.
2. I give permission for the physician to release information about my child's medical conditions to health office staff and school staff, as needed.

This authorization may be revoked by you at anytime in writing and expires in one calendar year.

Parent/Guardian Signature(s):_____/_____ Date: _____/_____

PARENT/GUARDIAN AUTHORIZATION OF ACTION PLAN

I authorize the above plan to be followed at school. The bus company is a separate entity from the school district. Please notify them directly of any specific directions for your child's care while riding the bus.

Parent/Guardian Signature(s):_____/_____ Date:_____/_____