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:

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

4041 Johnston Oehler Rd
Charlotte, NC 28269
Phone 704-717-7550

REQUEST FOR MEDICATION ADMINISTRATION

(each medication must be listed on a separate form)

Valid for school Year 20____ to 20____

Student Name:_____ **Date of Birth:**_____ **Current School Grade:**_____

Medication:_____ **Dosage:**_____ **Route:**_____

Time(s) medication is to be given: A.M. _____ **P.M.** _____ **PRN:** _____

Side effects, Interactions, Etc: _____

Prescribing Health Care Provider Signature:	**Date:**
Health Care Provider Name:	**Phone #:**

Parent/Guardian Agreement: I give my permission for my child (named above) to receive medication during school hours. I agree to send the medication in its original container. As the parent/guardian of this child, I assume the responsibility of any adverse reactions this medicine may cause for my child and I, hereby, release the Board of Directors, School Administration and employees from all liability. I understand that school staff will distribute medication based on the instructions on the original container. This will not be done by a nurse or under the supervision of a nurse.

Parent/Guardian Signature:	**Date:**
Parent/Guardian Name:	**Phone #:**

SELF-MEDICATION STUDENT AGREEMENT *(only applicable for 6th grade and above)*

- Non emergent medications are kept in the office.
- Emergent Medications that can be carried by student *(only if this form is completed and on file)*:
  - **Asthma/Allergic Reactions: ____MDI (Metered Dose inhaler) ____MDI with spacer**
  - **Diabetes: _____Insulin ____ Glucose**
  - **Anaphylaxis: ____Epinephrine**

Health Care Provider Agreement: I agree that this student is authorized to medicate himself/herself, has been instructed and has demonstrated the skill level necessary to use the prescribed medication/device. In order to keep this child in optimum health and to aid school performance it is necessary that this medication be self-administered during school hours. The student's parent/guardian has been informed and is in full agreement.

Healthcare Provider Signature:
(Signature also required at top of form)

Parent/Guardian Agreement: I agree that my child (named above) is knowledgeable of his/her treatment and is capable of self-administering this medication. I understand that the school and its employees are not liable for an injury arising from a student's possession and self-administration of medication. If applicable, I understand that I should provide the school with backup medication that shall be kept in the office so my child has immediate access to their medication in the event my child forgets or loses their supply. I understand that all non-emergent medications will be kept in the office and it is my child's responsibility to go to the office when the medications are due or needed.

Parent/Guardian Signature:
(Signature also required at top of form)

Self-Medicating Student Agreement: I agree and understand how to take my medicine as prescribed by my doctor. I will not share my medicine with anyone. I will keep my emergency medicine in a safe and secure place away from other students. My non emergent medications will be kept in the office and I will go to the office to take them at the scheduled time or as needed. I understand that if I do not follow the above rules, I may lose my privilege to give myself my own medicine while at school.

Student Signature:	**Date:**

To comply with requirements stated in G.S. 115C –375.2, the following must be developed/signed by the student's health care provider and accompany this form: • ***Emergency Action Plan*** *(for students needing an Epi-Pen, Asthma, or Seizure medication;)* • ***Diabetes Care Plan*** *(for students with diabetes).*

******Turn all forms into the front office.******

Nurse Signature_____ **Print** _____