Emergency Action Plan for Seizures

Student Name: ______________________________**DOB:** __________ **School:** _________________________**Grade** _____________

Parent/Guardian: ____**Phone:** ____

Emergency Contact: ____**Phone:** ____

A Seizure Disorder, also known as Epilepsy, is a disorder of the central nervous system characterized by a tendency for recurrent seizures. Seizures are due to sudden, temporary, bursts of electrical activity in the brain. These electrical bursts can cause involuntary changes in body movement or function, sensation, behavior or awareness.

Provide first aid if student has a seizure: (Stay.Safe.Side)

- STAY calm, keep calm, begin timing seizure
- Keep SAFE – remove harmful objects, don't restrain, remove restrictive clothing, and protect head
- SIDE – turn student on their side if not awake, keep airway clear, and don't put objects in mouth
- STAY until student has recovered from seizure
- Give medication as ordered if indicated. Location of medication: __________________________
- CALL 911 if MEDICATION IS GIVEN.
- Notify parent/guardian.

To be completed by Parent/Guardian:

Please provide any additional information about your child's seizure activity (auras, triggers, characteristics, etc):

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To be completed by Healthcare Provider:

Seizure Type	What may be observed during seizure

Emergency Medication Order:

If seizure (cluster, # or length)_____________________________ give (name of Med/Rx) ________________________
How much to give (dose) ____
How to give ____

Please include any additional information/interventions related to seizures to ensure student's needs are being met during the school day: ____
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This order remains in effect for the current academic year only and must be renewed each school year. The administration of this medication/treatment to the student during the school day is necessary to maintain and support the student's continued presence in school.

_____________________________________ ________ ____

Health Care Provider Signature **Date** **Phone Number/Office Stamp**

PARENT'S PERMISSION

I hereby give my permission for my child ______________________________________ to receive medication/treatment during school hours. This medication/treatment has been ordered and prescribed by a licensed physician. I hereby grant permission for the school nurse to communicate with the prescribing physician about the medication/treatment prescribed. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication/treatment. This consent is good for one year, and may be revoked at any time.

I will furnish all medications for use at school in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, the time/frequency it is to be given or taken, the route of administration, the number of doses in the container, and the expiration date of the medication). All over the counter medications will include the order for administration (first part of this authorization form signed by the doctor) with the identifying information, (name of child, medication dispensed, dosage prescribed according to label, and the time it is to be give or taken), with the medication in the original container.

I will replace this medication when it expires. I will remove this medication from the school the last day of school. I understand medication not picked up will be destroyed after the last day of school.

Parent or Guardian Signature: ____

Telephone number(s): ____

Emergency contact number in case you cannot be reached: ___________________________________