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:

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

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 _____

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

STAFFORD TOWNSHIP SCHOOL DISTRICT
PARENT PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

TO BE COMPLETED BY PARENT/GUARDIAN

I, _____ (parent/guardian), hereby give permission to the SCHOOL NURSE to administer the above medication to _____ (pupil's name).

By signing this form, I acknowledge and agree:

1) That I have received and carefully reviewed Policy 5330 and Regulation 5330;
2) That I have been informed in writing that the Stafford Township School District shall incur no liability as a result of any injury arising from the administration of this medication to my child.
3) That I shall indemnify and hold harmless the District and its employees or agents against any injury or claims that may arise as a result of the administration of this medication.
4) That I am aware that if I desire to withdraw permission for any designee to administer medication, I must do so in writing.

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**

Once completed, please make arrangements with the school nurse to drop off this form and your child's medication. The school nurse shall then review this form and forward to the Principal for completion. Please be advised that students cannot self-carry medication into school for delivery.

AUTHORIZATION - TO BE COMPLETED BY DISTRICT PERSONNEL

By signing this form, I acknowledge that I have received and reviewed all sections of this form and give my approval for administration of medication as set forth herein.

_____ _____

SIGNATURE OF SCHOOL PRINCIPAL **DATE**

_____ _____

SIGNATURE OF SCHOOL NURSE **DATE**

Once completed, the school nurse shall forward appropriate information to the Superintendent's office.