Futon Science Academy 2019 - 2020

SCHOOL SEIZURE ACTION PLAN FOR

_____ (INSERT NAME HERE)

Attach Student Photo

ABOUT

Name _____ Date of Birth _____ Grade

Doctors Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Seizure Type/Name: _____

What Happens: _____

How Long It Lasts: _____

How Often: _____

Seizure Triggers:

☐ Missed Medicine ☐ Emotional Stress ☐ Alcohol/Drugs ☐ Menstrual Cycle ☐ Missing meals

☐ Lack of Sleep ☐ Physical Stress ☐ Flashing Lights ☐ Illness with high fever

☐ Response to specific food, or excess caffeine Specify: _____ ☐ Other Specify: _____

DAILY TREATMENT PLAN

Seizure Medicine(s)

Name	How Much	How Often/When

Additional Treatment/Care: (i.e.: diet, sleep, devices etc.)

CAUTION–STEP UP TREATMENT

Symptoms that signal a seizure may be coming on and additional treatment may be needed:

☐ Headache ☐ Staring Spells ☐ Confusion ☐ Dizziness ☐ Change in Vision/Auras

☐ Sudden Feeling of Fear or Anxiety ☐ Other Specify: _____

Additional Treatment:

☐ Continue Daily Treatment Plan

- If missed medicine, give prescribed dose from above ASAP.
- Do not give a double dose or give meds closer than 6 hours apart.

☐ Change to: _____ How Much: _____ How Often/When: _____

☐ Add: _____ How Much: _____ How Often/When: _____

☐ Other Treatments/Care: (i.e.: sleep, devices): _____

Green Zone Less than 2 minutes	Yellow Zone 2 to 5 minutes	Red Zone More than 5 minutes or 3 or more seizures in an hour
* Begin seizure First Aid * Closely observe student until recovered from seizure * Notify parent/guardian * Return student to class	* Continue Seizure First Aid * Call for help * Prepare to administer Diastat/Versed * Closely observe student until recovered * Notify parent/guardian * Student may return to class/home as instructed by parent/guardian	* Continue Seizure First Aid * Administer Diastat/Versed * Monitor respirations and heart beat and start CPR if needed * Notify parent/guardian * Call 911 if seizure is greater than 7 minutes

DANGER–GET HELP NOW

Follow Seizure First Aid Below

☐ Contact School Nurse or Adult trained on rescue medication:

Name: _____ Number: _____

☐ Record Duration and time of each seizure(s)

☐ Call 911 if:

- Student has a convulsive seizures lasting more than ___ minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student is having breathing difficulty

When EMS arrives, a medical provider will perform an individual assessment to determine appropriate next steps.

Rescue Therapy:

☐ Rescue therapy provided according to physician's order:

_____

_____

POST SEIZURE RECOVERY

Typical Behaviors/Needs After Seizure:

☐ Headache ☐ Drowsiness/Sleep ☐ Nausea ☐ Aggression ☐ Confusion/Wandering ☐ Blank Staring

☐ Other Specify: _____

Reviewed/Approved by:

_____

Physician Signature Date

_____

Parent/Guardian Signature Date

SEIZURE FIRST AID

Image adapted with permission from the Epilepsy Foundation of America

LEARN MORE AND GET A DOWNLOADABLE VERSION OF THIS ACTION PLAN AT:

Child Neurology FOUNDATION
Creating a Community of Support
childneurologyfoundation.org/sudep

Danny Did FOUNDATION
dannydid.org

EPILEPSY FOUNDATION
SUDEP INSTITUTE
epilepsy.com/sudep-institute

EPILEPSY FOUNDATION® Not another moment lost to seizures® epilepsy therapy project

STRONGER TOGETHER

Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Contact Information

Student's Name	School Year 2019-2020	Date of Birth	
School **Fulton Science Academy**	Grade	Classroom	HR Teacher
Parent/Guardian	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	Location	
Significant Medical History or Conditions			

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? _____
2. Seizure type(s)

Seizure Type	Length	Frequency	Description

3. What might trigger a seizure in your child? _____
4. Are there any warnings and/or behavior changes before the seizure occurs? ❒ YES ❒ NO
   If YES, please explain: _____
5. When was your child's last seizure? _____
6. Has there been any recent change in your child's seizure patterns? ❒ YES ❒ NO
   If YES, please explain: _____
7. How does your child react after a seizure is over? _____
8. How do other illnesses affect your child's seizure control? _____

Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? ❒ YES ❒ NO
    If YES, what process would you recommend for returning your child 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

Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? ❒ YES ❒ NO
    If YES, please explain:

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

Seizure Medication and Treatment Information

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and Time of Day Taken	Possible Side Effects

14. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to Do After Administration

** After 2nd or 3rd seizure, for cluster of seizure, etc.* *** Orally, under tongue, rectally, etc.*

15. What medication(s) will your child need to take during school hours? _____
16. Should any of these medications be administered in a special way? ❒ YES ❒ NO
    If YES, please explain: _____
17. Should any particular reaction be watched for? ❒ YES ❒ NO
    If YES, please explain: _____
18. What should be done when your child misses a dose? _____
19. Should the school have backup medication available to give your child for missed dose? ❒ YES ❒ NO
20. Do you wish to be called before backup medication is given for a missed dose? ❒ YES ❒ NO
21. Does your child have a Vagus Nerve Stimulator? ❒ YES ❒ NO
    If YES, please describe instructions for appropriate magnet use:

Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

❒ General health _____ ❒ Physical education (gym/sports) _____
❒ Physical functioning _____ ❒ Recess _____
❒ Learning _____ ❒ Field trips _____
❒ Behavior _____ ❒ Bus transportation _____
❒ Mood/coping _____ ❒ Other _____

General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? _____
24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ❒ YES ❒ NO

Dates _____
Updated _____

Parent/Guardian Signature _____ **Date** _____

FULTON SCIENCE ACADEMY
— Private School —

REQUEST FOR ADMINISTRATION OF MEDICATION
20_19__ - 20_20__

*****ASK your pharmacist to make a separate prescription labeled bottle, and/or additional labels for each device of your inhaler, epinephrine auto injector, additional insulin, Glucagon or other prescribed medication for school, home, and for the one you carry. It is preferable that a second prescription device be kept at the school in case the first is lost or left at home.***

If medications can be given at home or after school hours, please do so. However, if medication administration is absolutely necessary to be given during school hours, this form must be completed.

Permission is hereby granted to the local school principal or his/her designee to supervise my child in taking the following prescribed medication.

I hereby release and discharge the Fulton Science Academy and its employees and officials from any and all liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication. I hereby release aforementioned officials from any liability because of any injury or damage which might occur.

I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

I understand that: All medications, herbals, and supplement must be approved by the U.S. Food and Drug Administration and appear in the U.S. Pharmacopeia

- **Medications must be in the original container.**
- Parent/Guardian must provide specific instructions (including drugs and related equipment) to the principal or his/her designee.
- It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data. New medications will not be given unless a new form is completed.
- All medication will be taken directly to the office by the parent or guardian. Students may not have medication in their possession, except with a physician's request or a physician's order on a Fulton Science Academy care plan.
- Students who violate these rules will be in violation of the Alcohol/Illegal Drug Use Policy (JCDAC).
- A daily record shall be kept on each medication administered. This record will include student's name, date, medication administered, time, and signature of school personnel who supervised.
- **MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN**. Any medication not picked up from the school by the end of the last school day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and an administrator.

NAME OF STUDENT _____**BIRTHDATE**_____**GRADE** _____
SCHOOL Fulton Science Academy Private School
MEDICATION **Diastat/Versed**_____**Amount to give** _____ **TIME to give**_____
ALLERGIES_____
PHYSICIAN'S NAME_____**PHYSICIAN'S PHONE**_____
Doctor Office Name_____ **FAX**_____

STATEMENT OF PARENT OR GUARDIAN

I hereby give my permission for my child to receive this medication at school.

SIGNATURE OF PARENT/GUARDIAN_____**DATE**_____
PHONE _____

To be completed by Physician for long-term medications (more than two weeks):"Physician" as defined in Article 2 of the Medical Practice Act of Georgia ***Medication that contains Aspirin, Pepto Bismol or ointments MUST have a doctor's signature

CONDITION/ILLNESS REQUIRING MEDICATION_____
POSSIBLE SIDE EFFECTS OF MEDICATION_____
OTHER MEDICATION STUDENT IS TAKING_____
PHYSICIAN'S SIGNATURE_____**DATE**_____

Date received: _____ # _____ Initial _____
Picked up Date: _____ # _____ Initial _____
Dropped off: _____ # _____ Initial _____

Expiration Date: _____
Disposed of date: _____ # _____ Initial _____