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 Contact: _____ Phone:_____Cell:_____

Treating Physician:_____ Phone: _____

Significant medical history:_____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:_____

Student's reaction to 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 (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as:

A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other Trained Staff_____

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Emergency Medication	Dosage	Special Instructions

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use_____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

Describe any special considerations or precautions:

Physician Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Houston Independent School District
Health and Medical Services

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

This form must be filled out completely to allow the School Nurse and /or other trained staff assigned by the Principal to administer medication to a student. A new medication form must be completed at the beginning of each school year for each prescription medication, and each time there is a change in the medication's administration instructions.

In accordance with district policy, only prescription medication will be administered.

- Prescription medication must be delivered to school in its original container.
- The container must be properly labeled by a pharmacist.

Student's Name _____ Sex_____

Date of Birth _____ / _____ / _____ Name of School _____

Medical Diagnosis: _____ ☐Infectious ☐Non-Infectious ☐Allergy

Medication Name: _____

Dose (amount to be given): _____

Frequency (how often): _____

Form of Medication (Route): _____

☐tablet ☐pill ☐capsule ☐liquid ☐inhalation ☐injection

☐ other (specify): _____

Possible side effects _____

Special requirements for administration / storage _____

Known food allergies YES NO If Yes, please explain _____

This is permission to give medication to my child named above as requested by the physician. I understand that I am giving consent for the school nurse to discuss any concerns regarding this medication with the healthcare provider whose signature appears on this document to monitor the healthcare needs of my child.

_____
Parent's Signature

_____
Telephone

_____
Date

_____
Physician's/Advanced Practice Nurse Signature

_____
Physician's/Advanced Practice Nurse Name (print or type)

_____
Date

_____
Facility Name

_____
Telephone

GJ/ab 07/08/2018
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