USD 261
HAYSVILLE

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Mary Parker, RN
District School Nurse

SEIZURE MEDICAL MANAGEMENT PLAN

Dear Parents or Guardian:

This plan should be completed by the student's physician and parents/guardian. Please have the physician to give guidelines on type of seizure, length, frequency and description of seizure and treatment protocol with daily and emergency medications used during school hours, so that the school staff will be clear on what is to be done.

Please also have the physician complete the attached form "Permission to Administer Medication." Please send all medication in original labeled container from the pharmacy and if student has a vagus nerve stimulator, please include magnet that is to be used.

Each school year this plan must be completed by the student's physician and parents/guardian. If you have any questions or concerns, please call the Nurse or Health Aide in your child's school.

Thank you,
Mary Parker, R.N.
District School Nurse for Haysville Schools

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** _____

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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 _____ Date of Birth _____

School _____ Grade _____ Classroom _____

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

Permission to Administer Medication
Haysville Public Schools
Health Services Department

Board Policy:

PRESCRIBED MEDICATION OR OVER-THE-COUNTER MEDICATION WILL BE GIVEN AT SCHOOL ONLY UPON WRITTEN REQUEST FROM BOTH THE LAWFUL GUARDIAN AND THE PUPIL'S LOCAL ATTENDING PHYSICIAN. THESE WRITTEN REQUESTS ARE **REQUIRED BEFORE ADMINISTRATION** OF EITHER THE SHORT TERM OR MAINTENANCE MEDICATION IS INITIATED.

This written statement will be kept on file at the school for the duration of the stated treatment. Long-term treatment will be updated **annually**. A change in medication dosages requires a new written notification with the attending physician's signature.

Medications:

A. Prescribed medication will be provided to the school by the lawful guardian in a properly labeled crushproof container. The label shall give the following information:
   a. Pupil's name
   b. Name of medication
   c. Dosage and directions for administration
   d. Date
   e. Prescribing physician's name

B. It is the lawful custodian's responsibility to assure the medication and dosage in the container is the same as is described by the label.

_____ _____
Name of Student to Receive Medication Date of Birth

_____ _____
Print Name of Physician Phone

Name of Medication and Dosage to be given_____

For the Diagnosis of_____

Directions for administration and any other pertinent information:

_____

_____

Requested starting date of treatment_____ Expected duration of treatment_____

Request to administer the medication during regular school hours.

_____ _____
Signature of Parent/Guardian Physician's Signature

_____ _____ _____ _____
Phone Date Phone Date

_____ _____
Address Address