Haysville Public Schools Seizure Action Plan and Medication Orders

Student's Name:	Birthdate:	Grade:
School:	Teacher:	
Primary Care Physician / Phone**:**		
Neurologist / Phone:		
Preferred Hospital:		

TO BE COMPLETED BY HEALTH CARE PROVIDER

Seizure Information

Seizure Type:	
Length of Typical Seizure:	
Warning Signs:	
Description of Seizures:	
Last Observed Seizure (month & year):	
Number of Seizures in Past Year:	

Please list any medications student is presently taking for control of seizures:

Medication	Dose	Time	Route	Give at School	Give at Home

Does student have a **Vagus Nerve Stimulator?** ☐ Yes ☐ No Where is magnet kept? _____

Describe Magnet Use: _____

Diastat (diazepam rectal gel) PRN Order:

Administer DIASTAT _____mg rectally for a continuous seizure or a cluster of seizures without a return to baseline lasting longer than _____ minutes.

Student should carry Diastat with him/her at all times while in school. ☐ Yes ☐ No
(If no, medication will be locked in the health room with other medications.)

Special Considerations and Precautions

Gym/Sports/Classroom restrictions: _____

School Trips: _____

Other: _____

Medical Provider: Your signature serves as the medical order for this plan of care including medication administration as outlined on this care plan.

_____ _____ _____

Physician Signature | Physician Name (print) | Date

Student Name: _____ DOB: _____

Basic Seizure First Aid	A seizure is generally considered an emergency when:
• Stay calm and track time • Keep child safe • Do not restrain • Protect the head • Keep airway open/watch breathing • Turn child on their side • Do not put anything in mouth • Stay with the child until fully conscious • Record seizure in log (if applicable)	• Convulsive seizure lasting 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 seizure in water

EMERGENCY ACTION:

- Call EMS (911) and notify school health staff immediately
- For absence of breathing and/or pulse, trained school staff should initiate CPR
- Notify patent/guardian or emergency contact

1. Parent:	Phone Number:
2. Emergency contacts: Name/Relationship	Phone Number(s)
a.	
b.	

I grant permission for Haysville Schools to exchange information with my child's health care provider and dispensing pharmacy identified on the medication label as deemed necessary. I hereby request that Haysville schools cooperate with the prescribing health care provider and assist with the administration of medication pursuant to the policy of the Haysville Schools. I have reviewed the above statements and agree to abide by Haysville Schools School District Policy regarding the administration of medication/procedures at school. I further release Haysville schools and school personnel from liability when my child self-carries and self-administers medication.

Parent/Guardian Signature: _____ Date: _____

School Nurse: _____ Date: _____