SEIZURE ACTION PLAN FOR SCHOOL

Student Name_____ D.O.B._____ ID # _____

School _____ Teacher_____

Physician _____ Phone: _____

Student Picture

EMERGENCY CONTACTS

Name	Relationship	Home #	Work #	Cell #
1.				
2.				
3.				

Type of seizure: _____

What does the seizure look like and how long does it usually last?_____

_____

Possible triggers that should be avoided: _____

_____

Does student need any special activity adaptations/protective equipment (e.g., helmet) at school?

_____No _____ Yes (explain)_____

_____

Is student allowed to participate in physical education and other activities? _____No _____ Yes (explain)

_____

ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES? _____No _____ Yes (List below the medications needed)

MEDICATIONS	**AMOUNT TAKEN**	**HOW OFTEN AND FOR WHAT SIGNS**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

List medication needed at school (name, dosage/route, and frequency) _____

_____

Possible side effects that must be reported to parent or physician: _____

_____

IF GENERALIZED SEIZURE OCCURS:

1. If falling, assist student to floor, turn to side.
2. Loosen clothing at neck and waist; protect head from injury.
3. Clear away furniture and other objects from area.
4. Have another classroom adult direct students away from area.
5. TIME THE SEIZURE.
6. Allow seizure to run its course; DO NOT restrain or insert anything into student's mouth. Do not try to stop purposeless behavior.
7. During a general or grand mal seizure expect to see pale or bluish discoloration of the skin or lips. Expect to hear noisy breathing.

Compass Academy
CHARTER SCHOOL

"Where all children will learn, lead and become the future."

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WHENEVER POSSIBLE, PARENTS ARE ADVISED TO GIVE MEDICATION AT HOME AND ON A SCHEDULE OTHER THAN SCHOOL HOURS. IF IT IS NECESSARY THAT A MEDICATION BE GIVEN DURING SCHOOL HOURS, THESE INSTRUCTIONS MUST BE FOLLOWED:

1. Medication must be brought in the School Nurse's Office, by an adult, at the beginning of the school day.
2. Medication to be given must be brought to school in the original container, with appropriate label intact.
3. Permission to dispense medication must be completed by prescribing physician/dentist.
4. Permission to administer medication must be by parent/guardian.

TO BE COMPLETED BY FAMILY PHYSICIAN/PRACTITIONER: (Please return to school nurse)

NAME _____ SEX____ BIRTHDATE____/____/____

PARENT OR GUARDIAN_____ HOME PHONE _____

HOME ADDRESS_____

SCHOOL_____ GRADE_____ TEACHER/HOMEROOM_____

In order to provide an appropriate educational program the following medication must be provided during the school day:

DIAGNOSIS_____

Medication	Route	Dose	Time	Nurse	Self	Assist

During a field trip:

In the event that the school nurse or a substitute cannot be sent on the trip, a student may not receive medication while on the field trip. If advisable, please give the school nurse directions on how to alter the student's medication regime for a field trip.

_____ The nurse may skip the medication during the school day, in the case of a field trip

_____ The medication may be given on an alternate schedule, for the day of the field trip.
The altered field day schedule is:_____.

_____ The student may self-administer asthma inhaler under supervision.

_____ _____
SIGNATURE OF PHYSICIAN OR DENTIST DATE SIGNED

_____ _____
PRINTED NAME OF PHYSICIAN OR DENTIST OFFICE PHONE NUMBER

TO BE COMPLETED BY PARENT/GUARDIAN:

The nursing staff has my permission to administer the above medication(s) to my child, as prescribed, during school and on field trips. I understand that all medication must be in the original container with appropriate label intact, and must be brought by an adult to the School Nurse's Office. The School Health Staff has my permission to contact my child's provider(s) for information or records as needed to care for my child.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE SIGNED

In the effort to avoid possible drug interactions, please list additional medications given at home.
Medication_____ **Dose**_____ **Time**_____

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