Jefferson Joint School District #251
Seizure Action Plan (SAP)

(For District Use)
Effective Date: _____

Student Name: _____ DOB: _____

Age at diagnosis: _____ School: _____ Grade: _____

Rescue medications will be: ❒ Stored in Office ❒ In Possession of Student – Location:_____

Does the student has a **VAGUS Nerve Stimulator (VNS)**? ❒ NO ❒ YES – Location:_____

SEIZURE INFORMATION:

Seizure Type	*How Long It Lasts*	*How Often*	*Description*

How to respond to a seizure (check all that apply):

☑ Provide Basic First Aid (see below) ❒ Give Emergency Medication (see below)

❒ Notify Parent/Guardian/Emergency Contact when:_____

Parent/Guardian/Emergency Contact ph#:_____

_____ _____

Basic Seizure First Aid:

☑ **STAY** calm, **TIME** the seizure

☑ Keep student **SAFE** – remove harmful objects, don't restraint, protect head

☑ Turn student on **SIDE** – keep airway clear, don't put objects in mouth

☑ **STAY** until student recovers from seizure

☑ **Document** on Seizure Log

❒ **Swipe magnet for VNS when:** _____

_____

❒ Other:_____

When to Call 911!

❒ Seizure with loss of consciousness that lasts longer than 5 minutes

❒ Any seizure that lasts longer than _____ minutes or more than _____ repeated seizures within a _____ minute time period

❒ Change in seizure type, number, or pattern than what is specified above

❒ Difficulty breathing after seizure

☑ Serious injury occurred or suspected, seizure in water, pregnancy, diabetes

☑ Emergency medication is administered

❒ Other (specify):_____

EMERGENCY MEDICATION ADMINISTRATION – When and What to administer

– if student receives emergency medication, he/she requires medical monitoring and cannot remain at school.

1. Medication Name **Dose** **Route** **Possible Side Effects**

_____ _____ _____ _____

When to administer:_____

_____

2. Medication Name **Dose** **Route** **Possible Side Effects**

_____ _____ _____ _____

When to administer:_____

_____

Student Name: _____

Return to Class: with no medication administered

Does the student need to leave the classroom after a seizure? ❒ No ❒ Yes.

If yes, please describe the process for returning the student to the classroom: _____

_____

Comments/Special Instructions (field trips, etc):

***The Seizure Action Plan with included Medication Prescription Information and Licensed Independent Provider and Parent/Guardian Signatures requires review or renewal annually.

TO BE COMPLETED BY PARENT/GUARDIAN – Authorization for Exchange of Confidential Student Information

I authorize my child's **Health Care Provider** (name) _____to exchange confidential health information with the District Nurse for the completion of this plan of care and to exchange health information and records for not more than 12 months after signature date.

Parent/Guardian Signature _____ **Date** _____

By signing authorization, I understand that the parties named above are permitted to exchange written and verbal information regarding my child. The parties may also accept a photocopy of this release form and give it the same full force and effect as the original. I further understand that I may revoke this authorization in writing at any time by providing a copy of my revocation to the parties named above. The information used or disclosed under this release might be disclosed by the school district as an educational record, pursuant to FERPA and might no longer be protected by HIPAA.

TO BE COMPLETED BY PARENT/GUARDIAN

As Parent/Guardian of the named student:

* I agree to indemnify, defend, and hold the School District harmless from any and all claims, actions, cost, expenses, damages, and liabilities, including attorney's fees, arising out of, connected with, or resulting from the administration of medication.
* I agree that the School District, Board of Education, Board of Education Employees and its Agents shall incur no liability as a result of any injury arising out of or connected with the administration of medication.
* I agree I will not institute either on our own behalf or behalf of the pupil, any claim or action against the Board of Education, Board of Education employees and its agents arising out of or connected with administration of medication.
* I understand this agreement must be signed and in full effect prior to the administration of medication.
* My child and I understand there are serious consequences for sharing any medication with others.
* I understand School Authorities will notify Parent/Guardian at the end of the school year to pick up medication. Medication which is not repossessed by the Parent/Guardian within a seven-day period of notification by school authorities will be destroyed by the District Nurse in the presence of a witness.
* I understand I am responsible to notify the District Nurse of any change in my child's health status, care, or medication order.

_____ ( )_____

Parent/Guardian Name (please print) Best Contact Phone Number

_____ _____

Parent/Guardian Signature **Date**

TO BE COMPLETED BY PHYSICIAN

As the student's Licensed Independent Provider (LIP), I confirm the student has a diagnosis of epilepsy and approve this emergency care plan, including medication prescribing information.

_____ ( )_____

Licensed Independent Provider (LIP) Name (please print) Phone Number

_____ _____

LIP Signature **Date**