FORSYTH COUNTY SCHOOLS
Quality Learning and Superior Performance for All

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:___________________

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:

Seizure Emergency Protocol: *(Check all that apply and clarify below)*
- ☐ Contact school nurse at ___________________________________
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other____

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
- ✓ Person is pregnant

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

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication**. If Administered, 911 will be called.**

____

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.)*

Physician Statement:

I am requesting the administration of Diastat/Intranasal Versed as ordered in the FCS Seizure Action Plan for the treatment of prolonged seizures in the school setting. I understand and agree that Diastat/Intranasal Versed will be administered by a trained lay person and that monitoring equipment such as blood pressure cuffs, oximetry, etc. will not be available at the school during administration.

_________________________ __________ ____________________________ ______________________________

Physician Name (PRINT) Physician Signature Date

Parent Signature:____ **Date:**____________________

Reviewed by: ____ **Date:**____________________

*Refer to 504 coordinator if appropriate

Updated 3/2019

Forsyth County Schools
Quality Learning and Superior Performance for All

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 student'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 Name:___________________Tel. (H):______(W):_______________(C):_________

Other Emergency Contact: ___________________Tel.(H):______(W):_________(C):_________

Child's Neurologist:_______________________Tel:________________Location:_____________________

Child's Primary Care Dr.:_________________________Tel:________________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 and Comfort Measures

9. What basic first aid procedures should be taken when your child has a seizure in school?______________________________________
____
____
____
____

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

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:_______________________
____
____
____

REQUEST FOR ADMINISTRATION OF MEDICATION

If medications can be given at home or after school hours, please do so. However, if medication administration is absolutely necessary to be given during school hours, this form must be completed.
Permission is hereby granted to the local school principal or his/her designee to supervise my child in taking the following prescribed medication.

I hereby release and discharge the Forsyth County Board of Education and its employees and officials from any and all liability in case of accident or any other mishap in supervising said medication due to any side effects, illness, or other injury which might occur to my child through supervising said medication. I hereby release aforementioned officials from any liability because of any injury or damage which might occur.

I give the above-mentioned personnel permission to contact my child's health care provider and/or pharmacy to acquire medical information concerning my child's diagnosis, medication, and other treatment(s) required.

I understand that:

All medications, herbals, and supplement must be approved by the U.S. Food and Drug Administration and appear in the U.S. Pharmacopeia
Medications must be in the original container.
Parent/Guardian must provide specific instructions (including drugs and related equipment) to the principal or his/her designee.
It will be the responsibility of the parent/guardian to inform the school of any changes in pertinent data. New medications will not be given unless a new form is completed.
All medication will be taken directly to the office by the parent or guardian. Students may not have medication in their possession, except with a physician's request or a physician's order on a Forsyth County care plan.
Students who violate these rules will be in violation of the Alcohol/Illegal Drug Use Policy (JCDAC).
A daily record shall be kept on each medication administered. This record will include student's name, date, medication administered, time, and signature of school personnel who supervised.
MEDICATIONS MUST BE PICKED UP BY PARENT/GUARDIAN. Any medication not picked up from the school by the end of the last school day of the year will be considered abandoned. Abandoned medication will be properly discarded in accordance with local, state, and federal laws/rules by the school nurse and an administrator.

NAME OF STUDENT ____ **BIRTHDATE** _______________
SCHOOL________________________________ **GRADE** ___________ **TEACHER** _______________
MEDICATION____________________________________ **DATE OF PRESCRIPTION** _______________
PHYSICIAN'S NAME______________________________ **PHYSICIAN'S PHONE** ______________
DOSAGE & TIME OF ADMINISTRATION____
ALLERGIES _____________________________________ **STOP MEDICATION ON**________________

STATEMENT OF PARENT OR GUARDIAN

I hereby give my permission for my child to receive this medication at school.

SIGNATURE OF PARENT/GUARDIAN__________________________________ **DATE** _____________
HOME PHONE _________________ **WORK PHONE** _________________ **CELL** _______________

To be completed by Physician for long-term medications (more than two weeks):
"Physician" as defined in Article 2 of the Medical Practice Act of Georgia

CONDITION/ILLNESS REQUIRING MEDICATION____
POSSIBLE SIDE EFFECTS OF MEDICATION____
OTHER MEDICATION STUDENT IS TAKING____

PHYSICIAN'S SIGNATURE ____________________________________ **DATE** _________________

Parent/Guardian Picked Up Medication Date ____________________

Parent Signature________________________ **Nurse**____________________ **Date**_________

ADMINISTRATION OF MEDICATION INFORMATION

(This information is on the reverse side of the Request for Administration of Medication Form)

The administration of medication to students during the school day presents an increased concern and awareness of the need to have written procedures.

Medication may be dispensed to students with the assistance of school personnel whenever physicians find it necessary to prescribe medication to be taken during school hours. School personnel will cooperate with parents in this regard by providing a place for the medication to be stored; however, *the major responsibility for a child taking medication at school rests entirely with the child's parents.*

A nurse is not always available to assist in the administration of the medication. The student may be assisted by an adult designated by the principal.

Prescription and non-prescription medication will be given to students by school personnel only when the following guidelines are observed:

***All medication MUST be in its original container and MUST be brought to school by the parent or guardian.** Medications brought in baggies or other unmarked containers will not be given. Prescription medication must be in the pharmacy container labeled with the child's name, date, name of medication, name of the prescribing physician, time(s) the medication is to be given and name of the pharmacy filling the prescription. We request that you ask the pharmacist to give you two labeled prescription bottles so that you have one bottle at home and one at school.

*A "Request for Administration of Medication" form (see back) must be completed by the parent/guardian (and physician if the medication needs to be given for longer than two weeks - such as (Ritalin) and sent to school along with the medication.

***Do not send medication to school which needs to be given daily or two/three times a day unless the physician specifically states a time during the school day which it is to be given.** An antibiotic which is to be given three times daily can be given before the child leaves for school, when he/she gets home, and at bedtime.

*School personnel cannot give medication that contains aspirin to students under 18 years old due to the correlation with Reyes Syndrome. Examples are Pepto Bismol, Excedrin Migraine, Goody's Powder.

The safety and well-being of your child are our concern. With your understanding and cooperation, we can eliminate much of the unnecessary medications that are brought to school and ensure that our students who do need to take medication at school will receive it appropriately. If you have any questions regarding medications, please call your child's school or you may call the school nurse.

AUTHORIZATION FOR STUDENTS TO CARRY A PRESCRIPTION INHALER, EPINEPHRINE AUTO INJECTOR, INSULIN, AND DIABETIC SUPPLIES, OR OTHER APPROVED MEDICATION

____ needs to carry the following prescription labeled inhaler, epinephrine auto injector, insulin, and diabetic supplies, and/or__________________________ prescription medication with him/her. The above-named student has been instructed in the proper use of the medication and fully understands how to administer this medication.

It is preferable that a second prescription inhaler, epinephrine auto injector, additional insulin, and diabetic supplies or other prescribed medication be kept in the school in case the first is lost or left at home.

Name of Medication: ____

____ ________________
Physician's Name *Date*

____ ________________
Physician's Address *Phone*

____ ________________
Physician's Signature *Date*

I have been instructed in the proper use of my prescription labeled medication and fully understand how it is administered. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be altered. I also accept responsibility for notifying the School Nurse each time I take my medication.

____ ________________
Student's Signature *Date*

I hereby request that the above-named student, over whom I have legal guardianship, be allowed to carry and use this prescribed medication at school:

- I accept legal responsibility should the medication be lost, given to, or taken by another person other than the above-named student.
- I understand that if this should happen, the privilege of carrying the medication may be altered.
- I release Forsyth County School System and its employees of any legal responsibility when the above-named student administers his/her own medication.

____ ______________________
Parent/Guardian Signature *Date*

Revised July 2020