

Haysville Public Schools Seizure Action Plan and Medication Orders

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

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: _____

Emergency Medication PRN Order:

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

Student should carry his/her emergency medications 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

TO BE COMPLETED BY HEALTH CARE PROVIDER

Student Name: _____

DOB: _____

Basic Seizure First Aid

- 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)

A seizure is generally considered an emergency when:

- 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 parent/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: _____