Austintown Local Schools

SCHOOL SEIZURE RECORD

(To be Completed by Parent/Guardian)

School records indicate your child has a seizure disorder. It is important to have at least annual information to provide support at school. Please complete this form and return to school immediately. If medication is to be given at school the attached **Seizure Action Plan is required** to be completed by physician and refer to our school policy on medication administration. **It is the parent/guardian's responsibility to inform the bus driver of your child's condition and to notify school immediately of any changes.**

Child's Name _____ Grade _____

Parent/Guardians(s) Name _____ Cell Phone _____

Home _____ Work _____

Physician Treating Child's Seizures _____ Phone _____

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1. When was your child's first seizure? _____ When was your child's most recent seizure? _____
2. What type of seizure does your child have? _____
3. What typically happens to your child during a seizure? (Example; rolls eyes, stares, etc…) _____

   _____
4. How long does the seizure usually last? _____
5. Can you identify what triggers the seizure (smell,light)? _____
   Can your child tell an adult of the potential onset of a seizure? _____
6. How frequently do the seizures occur? _____
7. Describe your child's behavior following a seizure _____
8. Does your child require a daily medication to help control the onset of seizures, if so please list name, dosage, and times given? _____
   Does your child require Diastat®? _____
9. Do you want 911 called in the event of a seizure? _____

Parent/Guardian Signature _____ Date _____

***If seizure is observed parent will be called.**

ADMINISTRATION OF MEDICATION TO STUDENTS DURING SCHOOL HOURS

All medication should be given at home when possible. The administration of prescribed medication and/or medically-prescribed treatments to a student during school hours will be permitted only when failure to do so would jeopardize the health of the student, the student would not be able to attend school if the medication or treatment were not made available during school hours, or if the child is disabled and requires medication to benefit from his/her educational program. In the event that it is necessary for a student to receive medication during the school day, the following requirements must be met prior to the administration of medication:

- **PRESCRIPTION MEDICATION:** An Administration of Medication Request Form must be completed and signed by both the physician and parent/guardian.

- **OVER-THE-COUNTER MEDICATION** (Nonprescription): An Administration of Medication Request form must be completed and signed by the parent/guardian.

- The first dose of any new medication will not be administered at school in case of an allergic reaction.

- It is the student's responsibility (age appropriate) to report to the clinic at the designated time to receive the medication ordered.

- All medication MUST be brought to school by the parent/guardian. Students are not permitted to carry or transport medication unless previously authorized by the school, physician, and parent/guardian and is an Emergency medication (i.e.; Inhaler, EpiPen).

- All Prescription medication must be labeled appropriately by the pharmacist or physician and in its original container. The label must state the student's name, dosage, and time(s) to be taken and must match the Administration of Medication Request form.

- All Nonprescription medication must also be in its original container and labeled with a permanent marker indicating the child's name. Medication not in its original container will not be administered to the student.

- The recommended dosage on the box of the nonprescription medication will be reviewed and compared to the parent/guardians request. If the dosage exceeds amount recommended on the medicine container/box, it must be requested by a physician's order on an Administration of Medication Request form.

- The principal or appointed representative will supervise the administration of the medication in the absence of the school nurse.

- Any change to the medication must be submitted on a new Administration of Medication Request form. If a prescriptive medication is to be discontinued, a written note must be provided by the practitioner.

- New Request forms must be submitted for each new school year and for each medication.

Parent(s)/Guardian(s) MUST pick up any unused medication. Medication will not be sent home with the child unless previously authorized and is an emergency medication. All medications not retrieved will be disposed of according to Ohio Revised Code.

AUSTINTOWN LOCAL SCHOOLS
SEIZURE ACTION PLAN

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student _____ Date of Birth _____

Mother/Guardian _____ Cell _____ Alternate Phone _____

Father/Guardian _____ Cell _____ Alternate Phone _____

Treating Physician _____ Phone _____

Significant Medical History _____

Current Medications _____ Allergies _____

SEIZURE EMERGENCY PROTOCOL:

☐ Diazepam rectal gel _____ mg rectally PRN for seizure > _____ minutes OR for _____ or more seizures in _____ hours. Following administration of Diazepam rectal gel, call parents to pick up child

☐ Use Vagal Nerve Stimulator (VNS) magnet

☐ Other _____

Call 911 if:

- ☐ Seizure does not stop by itself (or with VNS or after Diastat) within _____ minutes
- ☐ Child does not start waking up within _____ minutes after seizure is over (NO Diazepam rectal gel given)
- ☐ Child does not start waking up within _____ minutes after seizure is over (AFTER Diazepam rectal gel is given)

Following a seizure:

- ☐ Child should rest in clinic.
- ☐ Child may return to class (specify time frame _____)
- ☐ Notify parents immediately
- ☐ Notify physician.
- ☐ Other _____

Seizure Information – Student may experience some or all of the listed symptoms during a specific seizure.

Seizure Type(s)	Description	
☐ Absence	• Starting • Eye blinking	• Loss of awareness • Other _____
☐ Simple partial	• Remains conscious • Distorted sense of smell, hearing, sight	• Involuntary rhythmic jerking/twitching on one side • Other _____
☐ Complex partial	• Confusion • Not fully responsive/unresponsive	• May appear fearful • Purposeless, repetitive movements
☐ Generalized tonic-clonic	• Convulsions • Stiffening • Breathing may be shallow • Lips or skin may have bluish color	• Unconsciousness • Confusion, weariness, or belligerence when seizure ends • Other _____

Seizure typically lasts _____ minutes and returns to baseline in _____ minutes.

Triggers or warning signs _____

TURN OVER TO COMPLETE OTHER SIDE

AUSTINTOWN LOCAL SCHOOLS
SEIZURE ACTION PLAN

Basic Seizure First Aid	A Seizure is generally considered an EMERGENCY when
• 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	• 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
For tonic-clonic (grand Mal) seizure:	
• Protect head • Keep airway open/watch breathing • Turn child on side	
Restrictions/Special Considerations/Safety Precautions regarding school activities (sports, trip, etc) To be completed by physician: _____ _____ _____	

Health Care Provider Name _____ Phone:_____

Health Care Provider Signature _____ Date:_____

I give permission for school personnel to follow this plan, administer medication (if any) and care for my child and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Seizure Action Plan for my child. I also consent to the release of the information contained in this Seizure Action Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Parent/Guardian's Signature _____ Date_____

TURN OVER TO COMPLETE OTHER SIDE

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