

SEIZURE ACTION PLAN (SAP)



END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact/Relationship: _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☒

- | | |
|---|--|
| <input type="checkbox"/> First aid – Stay. Safe. Side. | <input type="checkbox"/> Contact school nurse at _____ |
| <input type="checkbox"/> Give rescue therapy according to SAP | <input type="checkbox"/> Call 911 for transport to _____ |
| <input type="checkbox"/> Notify parent/emergency contact | <input type="checkbox"/> Other _____ |

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked



When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is student able to resume usual activity? _____

Special instructions

First Responders: _____

Emergency Department: _____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____



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 child'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	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	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 & Comfort

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

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 seizure:**
- Protect head
 - Keep airway open/watch breathing
 - Turn child on side

Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? ☐ YES ☐ NO

If YES, please explain:

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts 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 a seizure in water

Seizure Medication and Treatment Information

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and Time of Day Taken	Possible Side Effects

14. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to Do After Administration

* After 2nd or 3rd seizure, for cluster of seizure, etc.

** Orally, under tongue, rectally, etc.

15. What medication(s) will your child need to take during school hours? _____

16. Should any of these medications be administered in a special way? ☐ YES ☐ NO

If YES, please explain: _____

17. Should any particular reaction be watched for? ☐ YES ☐ NO

If YES, please explain: _____

18. What should be done when your child misses a dose? _____

19. Should the school have backup medication available to give your child for missed dose? ☐ YES ☐ NO

20. Do you wish to be called before backup medication is given for a missed dose? ☐ YES ☐ NO

21. Does your child have a Vagus Nerve Stimulator? ☐ YES ☐ NO

If YES, please describe instructions for appropriate magnet use: _____

Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

- | | |
|---|--|
| <input type="checkbox"/> General health _____ | <input type="checkbox"/> Physical education (gym/sports) _____ |
| <input type="checkbox"/> Physical functioning _____ | <input type="checkbox"/> Recess _____ |
| <input type="checkbox"/> Learning _____ | <input type="checkbox"/> Field trips _____ |
| <input type="checkbox"/> Behavior _____ | <input type="checkbox"/> Bus transportation _____ |
| <input type="checkbox"/> Mood/coping _____ | <input type="checkbox"/> Other _____ |

General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? _____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ☐ YES ☐ NO

Parent/Guardian Signature _____ Date _____

Dates _____

Updated _____

Dr. Robert J. Underwood

Superintendent

Indian Lake Schools

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Coleen Reprogle

Treasurer

March 2022

Students with any medication to be stored or given at school such as daily, emergency or as needed, must provide the appropriate updated Medication Administration form **each school year**. There is a form for prescription medications that doctors sign and a different form for over the counter medications that parents simply sign when they drop off the medication for school.

Please note that Medication Administration Forms are also required for medications that students **self-carry**. Ohio law only lists 3 self-carry medications for school which include inhalers, epinephrine auto injector and glucagon. **ORC 3313.718** also states that in order for students to self-carry epinephrine auto injector, a second backup is to be received by the school. There is an area on the administration form for both the doctor and parent to sign consent for the student to self-carry these medications.

Remember students are not permitted to transport medications to/from school. A parent or guardian signature is necessary for medication to be signed in/out of clinic inventory. Finally, all medication **MUST** be stored in the original container with the label matching the signed doctor's order. For questions please contact District Nurse, Kourtney Thompson at 937-686-7323.

Sincerely,

Robert J. Underwood

Superintendent



Indian Lake Elementary School

8779 CR 91

Lewistown, Ohio 43333

Phone: 937-686-7323

Fax: 937-686-0049

Molly Hall, Principal

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Kyle Wagner, Principal

David Coburn, Asst. Principal

Indian Lake Local Schools

Medication Administration Form

(Including Asthma Inhaler and Epinephrine Autoinjector Use)

Student Information

Student name			Date of birth	
Student address				
School	Grade/Class	Teacher		School year
List any known drug allergies/reactions			Height	Weight

Prescriber Authorization

Name of medication		Circumstance for use	
Dosage		Route	Time/Interval
Date to begin medication		Date to end medication	
Circumstances for use			
Special instructions			
Treatment in the event of an adverse reaction			
Epinephrine Autoinjector <input type="checkbox"/> Not applicable <input type="checkbox"/> Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.			
Asthma Inhaler <input type="checkbox"/> Not applicable <input type="checkbox"/> Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.			
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief			
Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718			
a) To the student for whom it is prescribed (that should be reported to the prescriber)			
b) To a student for whom it is not prescribed who receives a dose			
Other medication instructions			
Does medication require refrigeration? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the medication a controlled substance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Prescriber signature		Date	Phone
Fax			
Prescriber name (print)			
Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.			

Parent/Guardian Authorization

<input checked="" type="checkbox"/> I authorize an employee of the school board to administer the above medication. <input checked="" type="checkbox"/> I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. <input checked="" type="checkbox"/> I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.			
<input checked="" type="checkbox"/> Medication form must be received by the principal, his/her designee, and/or the school nurse. <input checked="" type="checkbox"/> I understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.			
Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

<input type="checkbox"/> For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.			
<input type="checkbox"/> For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.			
Parent/Guardian signature	Date	#1 contact phone	#2 contact phone