Springboro Community City Schools Health Services

SEIZURE ACTION PLAN

Name: _____ DOB: _____/_____/_____

School/Grade: _____/_____ Homeroom: _____ BUS #: _____

Emergency Contact/Relationship _____Phone:_____

Seizure Type	How Long It Lasts	How Often	What Happens

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

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at _____
- ☐ Call 911 for transport to _____
- ☐ 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 _____ Dose _____

How to give: _____

Care After Seizure

What type of help is needed? _____

When is student able to resume ususal activity? _____

Epilepsy Provider Name: _____ ___ Phone #: _____

Special instructions _____

Completed by Clinic Staff/Medication Check-In/Processing:
Medication/Dosage: _____ Medication Expiration Date: _____
DASL Entry: _____ Health Concern List: _____ EAP Copies Made/Distributed: _____/_____
Medication Sign Out: _____/_____ Date: _____

OTHER Information *Student Involvement School:* Athletics_____ Band JROTC

Triggers: _____

Important Medical History _____

Allergies _____ Epilepsy Surgery (type, date) _____

Daily Seizure Medicine

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

Other information

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

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

To be Completed by the Parent:
I have read and understand Springboro Community City Schools Medication Policy. I give my permission for information to be sent to the school district via facsimile.
I, hereby, authorize designated personnel of the Springboro Community City School District to administer the above named medication or procedure as instructed by the physician, and agree to:

1. Provide the school with the medication in the container in which it was dispensed by the prescribing physician or licensed pharmacist.

2. Notify the school if we change physicians.

3. Notify the school if the medication, dosage, or procedures is changed or is to be eliminated.

4. Release authorized school employees from all liability, cause of action, or any other responsibility for administering said medicines as noted above.

Provider Signature _____ ***Date*** _____

Parent Signature _____ ***Date*** _____

Clinic Nurse Signature _____ ***Date*** _____