Kenai Peninsula Borough School District Health Services

This Student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

SECTION A. TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: _____ Date of Birth: _____ Room/Grade: _____

School: _____ Teacher: _____ Phone: _____ Fax: _____

Contact Information

Parent/Guardian #1: _____ Phone Number Home_____ Work_____ Cell_____

Parent/Guardian #2: _____ Phone Number Home_____ Work_____ Cell_____

Other/Relationship: _____ Phone Number Home_____ Work_____ Cell_____

Treating Healthcare Provider: _____ Phone: _____ Fax: _____

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

SECTION B. TO BE COMPLETED BY HEALTH CARE PROVIDER

Significant medical history: _____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

- Does student need any special activity adaptations/protective equipment (e.g., helmet) at school? _____ No _____ Yes (Explain) _____
- Is student allowed to participate in physical education and other activities? _____ No _____ Yes (Explain) _____
- Does student need to leave the classroom after a seizure _____ No _____ Yes If YES, describe process for returning student to classroom _____

BASIC FIRST AID: CARE & COMFORT

(Please describe basic first aid procedures)

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 _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Notify healthcare provider
- ☐ 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

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

SEIZURE ACTION PLAN

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

Emergency/Rescue Medication

Does student have a **Vagus Nerve Stimulator (VNS)**? _____ No _____ Yes, If YES, Describe magnet use_____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS *(regarding school activities, sports, trips, etc.)*

If you want additional care given, describe action here:

If symptoms are _____

Give (medication/dose/route) _____

Possible side effects_____

SECTION C. SIGNATURE BY PARENT/GUARDIAN, HEALTHCARE PROVIDER, SCHOOL NURSE

☐ **I want this plan implemented for my child, in school**. I hereby give my permission for exchange of confidential information contained in the record of my child between the nurse and physician and my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by nurse.

Parent/Guardian Signature:_____**Date:** _____

Healthcare Provider Signature_____ **Date**_____

Print Name_____ **Phone**_____ **Fax** _____

Effective Date of this plan_____**Ending Date:** _____

☐ **Approved by School Nurse**

School Nurse Signature: _____**Date:** _____