

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)*

**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 \_\_\_\_\_

**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

**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: \_\_\_\_\_