EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

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

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

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
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ 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 seizure:

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

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

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

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Tree of Life
CHRISTIAN SCHOOLS

Physician Authorization Form for Prescribed Medication

Student's Name _____ Date of Birth _____

Student's Address _____ Phone _____

School Branch _____ Grade _____

Medication to be administered _____

Does this medication have a generic name? _____

Dosage to be administered _____

Time/ interval when to be administered: _____

Date to begin administration_____ Date to Cease administration_____

Possible adverse reactions or side effects _____

List of severe reactions that should be reported to the physician _____

_____

Special instructions for storage of medication_____

Special instructions for administration of medication _____

Physician's Name _____Phone _____

Address _____Emergency Phone _____

_____

Physician's Signature Date

I give my permission for Tree of Life Christian Schools to administer the ***prescription medication*** listed above to my child _____ (child's name) at the time and dosage stated by the physician.

- I understand it is my responsibility to send an appropriate supply of medication I want Tree of Life to administer to my child during the current school year in its ***original container with my child's name on it***. This should be turned in to the front office. NO medication is permitted in book bags and/or lockers (**).
- The school reserves the right to prohibit the administration of any medications or procedures that appear to be beyond the ability of school personnel.
- The prescription medication for the student listed above cannot be scheduled for other than school hours. I agree to notify the school in writing of any changes in my child's condition with respect to the administration of medicine or with any changes to the information provided on this form.
- The school will keep a written account of medication administered to my child in school throughout the current school year.
- I do hereby release Tree of Life Christian Schools and any persons, employees, etc. designated by Tree of Life Christian Schools from and against any and all claims, demands or causes of action by any person for loss, cost, injury or damage alleged to rise from or out of the administration of medical services as requested above and authorized below.

_____ _____

Parent's/Guardian's signature Date

** Ohio state law permits students to carry metered dose or dry powder asthma inhalers and/or epipens approved by the student's physician and parents. If you are giving permission for your child to carry his/her inhaler and/or epipen on school premises or to school functions rather than keeping it in the school office, please initial here. _____

(Revised 2012)