# Groveport Madison Local School District
# Seizure Action Plan

Student Name: _____ DOB: _____ Age: _____
Home Room Teacher: _____ Grade: _____
Parent/Guardian: _____ Phone (C): _____
Phone (H): _____ Phone (W): _____
Health Care Provider/Physician Treating Student for Seizures: _____
Phone # _____
Other Health Care Provider: _____
Phone: _____

**Significant Medical History**:_____

## SEIZURE INFORMATION:

| *Seizure Type* | *Length* | *Frequency* | *Description* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Seizure Triggers or Warning Signs**:_____ _____

**Student's Reaction to Seizure**:_____

## BASIC FIRST AID/CARE:

*(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
_____

**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

## 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 doctor
- ☐ Administer emergency medications as indicated on **Prescribed Medication Authorization Form**
- ☐ 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

Does student have a **Vagus Nerve Stimulator (VNS)**? ☐ YES ☐ NO
If YES, Describe magnet use_____

**Comments/Special Instructions *(regarding school activities, sports, trips, etc.)***
_____
_____

**Physician Signature:**_____**Date:**_____

☑ I authorize the licensed healthcare professional to talk with the prescriber to clarify Seizure Action Plan.

**Parent Signature:**_____**Date:**_____

Please attach an extra sheet of paper for additional charting space

Adopted from the Epilepsy Foundation 5/2012 

# Groveport Madison Local School District
# Prescribed Medication Authorization

## 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
- ❑ Not applicable
- ❑ 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
- ❑ Not applicable
- ❑ 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? ❑ Yes ❑ No Is the medication a controlled substance? ❑ Yes ❑ 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

☑ I authorize an employee of the school board to administer the above medication. ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

☑ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☑ 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

*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.*

*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 |