HASBROUCK HEIGHTS PUBLIC SCHOOL
SCHOOL HEALTH SERVICES

SEIZURE PACK

TO BE COMPLETED BY THE PARENT & DOCTOR

Physician's Order for Medication

Seizure Action Plan

TO BE COMPLETED BY THE PARENTS

Questionnaire for Parents of a Student with Seizures
Health History Form
Authorization to Exchange

Updated 6/15/10

PHYSICIAN'S ORDER
FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

STUDENT'S NAME_____ DOB_____ GRADE_____

NAME OF DRUG_____

DOSAGE_____ TIME(S) TO BE ADMINISTERED_____

DIAGNOSIS / REASON FOR MEDICATION_____

POSSIBLE SIDE EFFECTS _____

DURATION OF USE_____

PHYSICIAN'S SIGNATURE_____ DATE_____

PLEASE PRINT OR STAMP:
PHYSICIAN'S NAME
ADDRESS
PHONE NUMBER

PARENT AUTHORIZATION
FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

I request that the above medication, in the original container, be administered to my child. I understand that a certified school nurse or her designated nurse substitute will be performing this service utilizing the order provided by my physician. I acknowledge that the school district and its employees and agents shall incur no liability as a result of administration of this medication to my child. I give the school nurse permission to contact the physician and / or pharmacist with any question concerning the medication.

PARENT / GUARDIAN'S SIGNATURE_____ DATE_____

HOME PHONE_____ WORK / CELL PHONE_____

INITIAL MEDICATION SUPPLY:

Name of medicine_____# of pills/tablets/capsules/ml._____

Nurse signature _____***Parent signature***_____

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:_____

Treating Physician:_____ 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 & 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

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:

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

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 below
- ☐ Other_____

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

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

Emergency/Rescue Medication

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use_____

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

Physician Signature:_____ **Date:**_____

Parent Signature:_____ **Date:**_____

STUDENT'S NAME_____ DOB_____ GRADE_____

MEDICATION SUPPLY RECORD:

DATE	MEDICINE	#	PARENT SIGNATURE	NURSE SIGNATURE

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Contact Information

Student's Name	School Year	Date of Birth	
School	Grade	Classroom	
Parent/Guardian	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	Location	
Significant Medical History or Conditions			

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? _____
2. Seizure type(s)

Seizure Type	Length	Frequency	Description

3. What might trigger a seizure in your child? _____
4. Are there any warnings and/or behavior changes before the seizure occurs? ❒ YES ❒ NO
   If YES, please explain: _____
5. When was your child's last seizure? _____
6. Has there been any recent change in your child's seizure patterns? ❒ YES ❒ NO
   If YES, please explain: _____
7. How does your child react after a seizure is over? _____
8. How do other illnesses affect your child's seizure control? _____

Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? ❒ YES ❒ NO
    If YES, what process would you recommend for returning your child 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 seizure:

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

Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? ❒ YES ❒ NO
    If YES, please explain:

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

Seizure Medication and Treatment Information

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and Time of Day Taken	Possible Side Effects

14. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to Do After Administration

** After 2nd or 3rd seizure, for cluster of seizure, etc.* *** Orally, under tongue, rectally, etc.*

15. What medication(s) will your child need to take during school hours? _____
16. Should any of these medications be administered in a special way? ❒ YES ❒ NO
    If YES, please explain: _____
17. Should any particular reaction be watched for? ❒ YES ❒ NO
    If YES, please explain: _____
18. What should be done when your child misses a dose? _____
19. Should the school have backup medication available to give your child for missed dose? ❒ YES ❒ NO
20. Do you wish to be called before backup medication is given for a missed dose? ❒ YES ❒ NO
21. Does your child have a Vagus Nerve Stimulator? ❒ YES ❒ NO
    If YES, please describe instructions for appropriate magnet use:

Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

❒ General health _____ ❒ Physical education (gym/sports) _____
❒ Physical functioning _____ ❒ Recess _____
❒ Learning _____ ❒ Field trips _____
❒ Behavior _____ ❒ Bus transportation _____
❒ Mood/coping _____ ❒ Other _____

General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? _____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ❒ YES ❒ NO

Dates _____
Updated _____

Parent/Guardian Signature _____ **Date** _____

HASBROUCK HEIGHTS PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES

Health History Questionnaire

To the parents or guardians of _____

It is important we have this information for your child's well-being during his/her school hours. Please complete and return this form to the School Nurse as soon as possible.

1. Does he/she have a medical Problem? If yes, please state problem:

_____

_____

_____

_____

_____

2. Is he/she on medication? If yes, pleas list medication(s):

_____

_____

3. Are there any restrictions? If yes, please list restrictions:

_____

_____

4. Does your child have any allergies to food or medication? If yes, what:

_____

_____

This information will be shared with staff as necessary. If you DO NOT want this information shared, please notify me immediately. Thank you for your cooperation in this matter.

Parent Signature:_____ Date: _____

UPDATED 1/23/09