New Albany-Floyd County Consolidated School Corporation School Health Services
2017-2018 School Year

Seizure Action Plan

To be completed by prescribing Health Care Provider

Student Name: _____ Date of Birth: _____ School: _____ Grade: ___ Teacher: _____

DESCRIPTION OF SEIZURE:

Expected Type	Length	Freq	Description
☐ Tonic-Clonic (Grand Mal)			
☐ Absence (Petit Mal)			
☐ Simple Partial			
☐ Complex Partial			
☐ Other _____			

Does the student have a Vagal Nerve Stimulator? ☐ Yes ☐ No

VNS magnet should be kept with student at all times

If student has **VAGAL NERVE STIMULATOR**, please specify when to use and how often (i.e. Every minute X 4, then administer Diastat):

_____

Does the student have Diastat? ☐ Yes ☐ No

If student has **DIASTAT**, please specify:
DOSE: _____ MG PER RECTUM FOR THE FOLLOWING SEIZURE TYPE: _____, TO BE ADMINISTERED AT:

☐ Onset of seizure
☐ _____ minutes after onset of seizure
☐ For _____ or more seizures in _____hour(s)
☐ Other: _____

Does the student have other medication for during seizure? ☐ Yes ☐ No

If student has **OTHER MEDICATION to use during seizure**, please specify:

Name _____

Dosage _____

Time/Symptoms requiring med _____

Prescribing Health Care Provider:

The Seizure Action Plan and medication orders have been developed and approved by:

_____ _____ _____

Prescriber Printed Name Phone Fax

_____ _____

Prescriber Signature Date

Parent/Guardian:

I give permission to the school nurse and other trained personnel members to perform the tasks as outlined in the Seizure Action Plan. I understand that a school nurse is not always present at my child's school and I give consent for other trained school personnel to provide care to my child as needed according to this plan. I give permission for the school nurse and prescribing health care provider to exchange information regarding any necessary medication order clarifications, response to medication, and adverse effects. I also consent to the release of information contained in this Seizure Action Plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____ _____

Student's Parent/Guardian Signature Date

THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR