Physician Order
Emergency Seizure Medication

Student Name_____ DOB: _____

Medication: _____ Route: _____

Dose_____ Time: _____ Frequency: _____

As per the student's Seizure Action Plan, the above listed medication has been ordered for:

☐ Refractory Seizures (Seizures not controlled by anti-seizure medication)

☐ Prolonged Seizures ☐ Cluster Seizures ☐ Other

As per Y.A.L.E. policy **911 EMS will be called anytime an emergency medication is administered.**
In recognition that the State of New Jersey's Nurse Practice Act does not allow delegation of the administration of Emergency Seizure Medication and that only trained medical professionals may administer Emergency Seizure Medication in the school setting:

Please check one:

☐ Student must be accompanied by a health care professional on all out of school field trips.

☐ Student may be accompanied by teaching staff who have been given training on seizure first aid by the school nurse and have reviewed the student's Seizure Action Plan, which will be taken on all field trips. In the event that a trained medical professional is not available, teaching staff will:

1. Institute First Aid protocol as per Seizure Action Plan
2. Immediately call EMS 911
3. Supply EMS Personnel with Seizure Action Plan
4. Notify parent/guardian

When it is determined, by the student's treating neurologist, that the need for the use of the above emergency medication in the school is no longer needed, the school nurse must be notified in writing and this medication order will be discontinued.

_____ _____

Treating neurologist signature Date Stamp

I understand that as the above named student's parent/guardian that the school nurse will not administer Seizure Emergency mdication more than 5 times in a month, and or more than once in 5 days, according to manufacturers dosing recommendations. It is further understood that as the parent/guardian authorizing emergency administration of Seizure Emergency medication, I will notify the school nurse or school administrator if the emergency medication has been administered at any time while the child has not been present at school. Such notification shall be given after administration of medication, before or at the begining of the next school day in which the student is in attendance. I also understand that I must notify the school nurse of any changes or additions to my child's daily medications. Y.A.L.E. School will not be held liable for any adverse reactions that a student has, especially when knowledge of new medications or Seizure emergency medications are given at home, and not shared with the school nurse or administrator by the first day the student returns to school following home administration.

_____ _____

Parent/guardian signature Date

SEIZURE ACTION PLAN (SAP)

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Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

Epilepsy.com

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EPILEPSY FOUNDATION

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