Seizure Action Plan
and Medication Consent Form

Instructions

Page 1 and Page 2: All students. To be completed and signed by Healthcare Provider and Parent/Guardian

Page 3: MHS students only. Open campus lunch permission form to be signed by Parent/Guardian.

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:

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

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 ____

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** ______________

DPC772

Copyright 2008 Epilepsy Foundation of America, Inc.

MONTCLAIR PUBLIC SCHOOLS

Rectal Diastat/ Intranasal Midazolam Consent Form

Student's Name____ D.O.B. ________________________

Parent/Guardian's Name___________________________________ Date __________________________

Telephone: Cell____________________ Work_________________ Home _________________________

PART 1- To be completed by student's Primary Healthcare Provider (MD, DO, APN) or Neurologist

A. <u>MEDICATION ORDER:</u>

I certify that it is essential to the health of ___________________________________ that the following medication be administered by the school nurse during school hours as directed. This student will not be able to attend school or school sponsored events without this medication.

Diagnosis: _______________________________Date of Last Documented Seizure: __________________

Name of Medication: ______________________________________Dosage: ________________________

Mode of Administration: __________ Frequency of Administration: ______________________________

Date of Last Documented Seizure: ________________

Date of Last Administration of Diastat/Midazolam: ____

Side Effects of Medication: ____

Length of Time Order is Valid (may not exceed school year):_____________________________________

______ **MEDICATION MAY BE OMITTED ON A CLASS TRIP**

Signature and Stamp of Primary Healthcare Provider (MD, DO, APN) or Neurologist:

____ **PHONE#** __________________________________

PART 2- To be completed by student's Parent/Guardian

Parent/Guardian Permission for School Nurse/Substitute School Nurse Administration of Medication
I give permission for the school nurse to administer the medication described on the reverse side. I will notify the nurse immediately if this medication is no longer required. I disclaim all liability of the Montclair Board of Education as it concerns the use of this medication.
I further understand that this permission is effective only for the school year for which it is granted.
All medication must be delivered to the school nurse by the parent/guardian.
All medication must be in the original pharmacy-labeled container with the prescription affixed or it will not be administered by the school nurse.
Any unused medication must be picked up by the student's parent/guardian. Medication not picked up by the last day of school will be discarded.
Parent/Guardian Name (please print) ____
Parent/Guardian Signature _______________________________ Date: ________________________

MONTCLAIR HIGH SCHOOL DIASTAT/MIDAZOLAM CONSENT

Parent/Guardian Permission for Open Campus Lunch

Subject to certain rules and regulations, high school students are permitted to leave the building and grounds during his/her assigned lunch period. **I understand that I am responsible for my child and his/her actions when he/she leaves the school building and/or school grounds, including medical needs**. I understand and accept that neither the Montclair Board of Education nor its members, agents, servants or employees will in any way monitor and/or control my child's whereabouts or safety, or be responsible for my child's acts or omissions, while my child is away from his/her school building and school grounds.

I agree to defend, indemnify and hold harmless the Montclair Board of Education and/or its members, agents, servants or employees or other representatives from any and all liabilities, claims, physical injury, bodily injury, damages, losses and expenses, including reasonable attorneys' fees, that may arise out of and/or in connection with my child's departure from his/her school building and/or school grounds in connection with my child's open lunch period. This indemnification agreement's scope of coverage shall include, but not be limited to, bodily injuries suffered by my child, other students, Board employees and/or any other persons.

Parent/Guardian's Signature________________________________ Date __________________

Rev. 2/2017