Galloway Township Public Schools
Seizure - Individualized Emergency Health Care Action Plan

Effective Date: _____

The below student is being treated for a seizure disorder. This information below should assist you if a seizure or any suspected seizure-like activity occurs during school hours.

STUDENT INFORMATION: **(*Parent/Guardian Complete*)**

Student's Name	Date of Birth	School	Grade	School Year
Parent/Guardian		Contact Phone Number		
Other Emergency Contact		Contact Phone Number		
Treating Physician		Phone Number		

SEIZURE INFORMATION **(*Physician Complete*)**

Seizure Type	Length	Frequency	Description/Symptoms

Seizure triggers or warning signs: **Student's response after a seizure:**

Date of last seizure: _____

BASIC FIRST AID: Care and Comfort ***(Physician Complete)***

Describe basic first aid procedures:

Basic Seizure First Aid

- Stay calm/seek assistance
- Note and record start/end time of seizure
- Clear area of harmful objects/protect head
- Turn on side if lying down
- Keep airway open/monitor breathing
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious

Does student need to go home after a seizure? _____Yes _____No
Does parent/guardian need to be contacted after any suspected seizure activity, regardless of duration? _____Yes _____No

EMERGENCY RESPONSE **(*Physician Complete*)**

A "seizure emergency" for this student is defined as

Seizure Emergency Protocol

- ☐ Call 911 at _____ minutes for transport to _____
- ☐ Call 911 in absence of breathing and/or pulse
- ☐ Call 911 if student is having multiple seizures
- ☐ Call 911 if student is injured
- ☐ Call parent or emergency contact
- ☐ Administer emergency medications as indicated

Does student have a VAGUS NERVE Stimulator? _____Yes _____No If YES, describe magnet use: _____

Special Considerations and Precautions Related to Child's Seizure Disorder **(*Physician Complete*)**
(Include Accommodations and indicate N/A as appropriate)

Educational concerns

_____

_____

Exercise and sports

_____

_____

School trips, after-school activities, class parties

_____

_____

Transportation

_____

_____

Expected Student Outcomes/Self-Care **(*Physician Complete*)**

Does child wear alert tag? _____Yes _____No
Does child have basic understanding of seizure disorder? _____Yes _____No
Does child recognize aura or behavior prior to seizure activity? _____Yes _____No
Is child knowledgeable about prescribed rescue treatment plan (if applicable)? _____Yes _____No
Does child self-carry emergency medication/equipment (requires healthcare provider order)? _____Yes _____No
If yes, list specific medication/equipment student carries in "Other" space below.
Other: _____

MEDICATION PROTOCOL – List all medications child is currently taking: **(*Physician Complete)***

Rescue Med? Y/N	Medication	Dosage	Route	Time	Frequency	Common Side Effects & Special Instructions

Physician Order for Administration of Medication ***(Physician Complete)***

_____ _____
Physician/Health Care Provider Signature Date

_____
Physician/Provider Name, Address, Phone Number

Parent/Guardian Consent for Management of Health Condition ***(Parent/Guardian Complete*)**

I, the parent/guardian of _____, request that this School Health Care/Emergency Plan be used to guide care for my child. I agree to:

- Provide necessary supplies and equipment.
- Notify the school nurse of any changes in the student's health status.
- Notify the school nurse and complete new consent for changes in orders from the student's healthcare provider.
- Authorize the school nurse to communicate with the primary care provider/specialist about this health condition.
- Consent that school staff interacting directly with my child may be informed of their special needs while under their care and receive a copy of this care/emergency plan and instruction from the nurse about it.

Parent/Guardian Consent to Administer Medication ***(Parent/Guardian Complete*)**

I request and grant permission for the school nurse to administer medication to my child, _____, as prescribed by his/her/their physician as indicated on this form and as per the policy of the Galloway Township Board of Education and State law. I understand that medication is to be brought to school by myself in the original prescription bottle/box labeled properly by the physician or pharmacist.

_____ _____ _____
Parent's/Guardian's Signature Date Phone Number

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Nurse – Distribution of Seizure Plan (this form) to 'need to know' Staff

- ☐ Front office/Admin Date Completed: _____
- ☐ Teacher(s) Date Completed: _____
- ☐ Transportation Date Completed: _____
- ☐ Child Care Date Completed: _____
- ☐ After-school Activities Date Completed: _____

Other: Specify: _____

_____ _____

School Nurse Signature Date

4-20-21