EPILEPSY FOUNDATION®
Not another moment lost to seizures™

MARYVILLE SCHOOL DISTRICT SEIZURE ACTION PLAN

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)

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 (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

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:**_____

MARYVILLE R-II SCHOOL DISTRICT
PARENTAL PERMISSION FOR
STUDENT MEDICATION ADMINISTRATION

The Maryville R-II School District's Medication Policy requires written parental/guardian consent prior to giving any prescription or over-the-counter medications at school. This form is to be completed for each medication given. **Medication is to be supplied in the original container with only a 30 day supply each time brought by a parent/guardian or other responsible adult. A new written medical provider order must be presented for any medication changes.**

If the medication is a prescription, ask your pharmacist to prepare two labeled containers, one to be kept at school and one for home. **THE VERY FIRST DOSE OF MEDICATION WILL NOT BE GIVEN AT SCHOOL.**

Student Name_____ Grade_____

Name/Dosage of Medication_____

Time to be Taken _____

Form of Medication/Treatment ____Tablet/Capsule ____Liquid ____Inhaler ____Other

Reason for Medication_____

Physician's Name_____

Medication to be Given From_____ TO_____
(Start Date) (End Date)

When was First Dose of Medication Given? _____

List Student's allergies_____

I request the above medication or treatment be administered to my child at school. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school nurse immediately if any information provided on this form changes. I give permission for the school nurse to communicate with the above physician or medical provider regarding any questions or concerns about the above medication or treatment. I also agree to pick up any remaining medication within one day after the last day of school or the school will dispose of the medication.

_____ _____
Parent/Guardian Signature Date