Frankford Township School District

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SEIZURE ACTION PLAN AND PHYSICIAN'S ORDERS

Parents:

- Complete and sign bottom half of the **Physician's Administration of Prescription and Non-Prescription Medications Form**
- Sign bottom area of the **Seizure Action Plan**

Physician:

- Complete, sign and stamp the **Physician's Administration of Prescription and Non-Prescription Medications Form**
- Complete, sign, and stamp the **Seizure Action Plan**

When forms are completed, an adult needs to bring them into school with medications. **Students may NOT carry medications into school.** Medications need to be in their **original, pharmacy labeled containers. Please ensure that the expiration date on the meds covers the school year.**

Thanking you for your attention and cooperation.

Sonia Kelleher
School Nurse

2 Pines Rd.
Branchville, NJ 07826

973-948-3727
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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** _____

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Frankford Township School
2 Pines Road
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Physician's Instructions for ADMINISTRATION OF PRESCRIPTION AND NON PRESCRIPTION MEDICATION

Student's Name: _____ DOB: _____ Grade: _____

TO BE COMPLETED BY THE PHYSICIAN:

Medication and Dosage: _____

Diagnosis for which medication is given: _____

Indications for use: _____

How soon may it be repeated: _____

Can a reaction be expected? If so, describe: _____

Follow up care: _____

When discontinued (i.e. end of school year): _____

The student is physically fit, is free of contagious disease, but would not be able to attend school if this medication is not administered during school hours.

_____ _____ _____
Student's Physician Signature **Date** **Phone Number**

MEDICATION AUTHORIZATION FORM

School Year _____/_____

I grant the school nurse or designated substitute permission to administer the above medication to my child named below:

My child may/should take his/her medication on half days: ____ YES ____ NO

My child may/should take his/her medication on delayed openings: ____ YES ____ NO

My child may/should take his/her medication on field trips: ____ YES ____ NO
(*If a school nurse is not present on field trip, no medication will be administered.*)

I am aware that this medication must be delivered to the school in its original, unopened, labeled container by the parent/guardian.

_____ _____
Student's Name Grade

_____ _____
Parent/Guardian Signature Date