Bexley City Schools

Seizure Action Plan

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 _____

Bexley City School District

To provide educational experiences that engage, equip and empower each student.

Cassingham Complex Clinic · Phone: (614) 237-4309 ext 3146, Fax: (614) 338-2090
Montrose Clinic · Phone: (614) 237-4226 ext 473, Fax: (614) 338-2088
Maryland Clinic · (614) 237-3280 ext 272, Fax: (614) 338-2080

PRESCRIPTION MEDICATION AUTHORIZATION FORM

Student name _____ **DOB** _____

Address _____

School _____ **Grade** _____ **Teacher** _____

PHYSICIAN'S AUTHORIZATION

_____ **is under my care and is prescribed to take:**

Name of student

_____ _____ _____

Name of medication* Dosage* Route

_____ _____

Start Date of Administration End Date of Administration (end of school year)

_____

Reason for administering medication (ie: diagnosis, health concern)

POSSIBLE MODERATE-SEVERE SIDE EFFECTS TO WATCH FOR:

_____ _____ _____

Physician Signature Phone Date

*Note: A new authorization form must be completed if any change is made to this prescription and must be updated each school year.

OHIO REVISED CODE 3313.713 (E)

In accordance with Ohio Revised Code 3313.713 (E) this completed form is required in order for drugs to be administered to students during the school day by school authorized persons. Per the statute, "no person who has been authorized by a board of education to administer a drug, and has a copy of the most recent authorization form is liable in civil damages for administering or failing to administer the drug, unless such person acts in a manner that constitutes gross negligence or wanton or reckless misconduct.

I have read and understand the above statement:

Parent/Guardian Signature _____ Phone _____ Date _____

THIS FORM MUST BE COMPLETED AND RETURNED TO THE NURSE AT THE SCHOOL SITE **BEFORE** ANY MEDICATION CAN BE ADMINISTERED BY SCHOOL AUTHORIZED PERSONNEL.

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ADMINISTRATION OF MEDICATION

1. Designated persons employed by the Board are authorized, in conjunction with Board policy, to administer to a student a drug prescribed by a physician for the student.

2. No drug prescribed by a physician for a student can be administered pursuant to these regulations or pursuant to the Education for All Handicapped Act unless the following occur:

A. The Board, or a person designated by the Board, received a written request, signed by the parent, guardian, or other person having care of charge of the student, that the drug be administered to the student. It is advised that the medication in its **original container** and the signed permission forms be brought to the school by the parent/guardian for elementary students.

B. The Board, or a person designated by the Board, receives a statement, signed by the physician who prescribed the drug, that includes **ALL** of the following information:

1. The name and address of the student
2. The school and class in which the student is enrolled
3. The name of the drug and the dosage to be administered
4. The times or intervals at which each dosage of the drug is to be administered
5. The **Date the administration is to Begin**
6. The **Date the administration is to Cease**
7. Any severe adverse reactions that should be reported to the physician and one or more phone numbers at which the physician can be reached in an emergency
8. Special instruction for administration of the drug, including sterile conditions and storage

C. The parent, guardian, or other person having care or charge of the student agrees to submit a revised statement signed by the physician who prescribed the drug to the Board, or a person designated by the Board, **if any of the information provided by the physician as described above changes.**

D. The person authorized by the Board to administer the drug receives a copy of the statement described above.

E. The drug is received by the person authorized to administer the drug to the student for whom the drug is prescribed in the container in which it was dispensed by the prescribing physician or a licensed pharmacist and have an affixed label including the student's name, name of medication, dosage, route and time of administration, physician's name, and date prescription filled.

THIS FORM MUST BE COMPLETED AND RETURNED TO THE NURSE AT THE SCHOOL SITE **BEFORE** ANY MEDICATION CAN BE ADMINISTERED BY SCHOOL AUTHORIZED PERSONNEL.