School Year _____

Seizure Action Plan

Bus # _____

Student's Name	Date of Birth	Grade/Teacher
Parent/Guardian	Phone	Cell
Other Emergency Contact	Phone	Cell
Treating Physician	Phone	Fax

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

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

Basic First Aid: Care & Comfort

Please describe basic first aid procedures if different than shaded box at right:

Does student need to leave the classroom after seizure? ☐ Yes ☐ No
If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm and track time
- Keep child safe
- Do no 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 students is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

☐Contact school nurse at _____
☐Contact 911 for transport to _____
☐Notify parent or emergency contact
☐Notify doctor at _____
☐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)

Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

☐ **Diastat _____mg rectally for seizures lasting more than _____minutes** *(provided by parent)*

☐ **If seizure continues for more than _____ minutes after Diastat administration, call 911.**

☐ **Oxygen at _____liters/min via _____ during seizure** *(physician order required / 0_2 provided by parent)*

Does Student have a **Vagus Nerve Stimulator?** ☐ Yes ☐ No If YES, location: _____

If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Designation of Rescue Drug (Diastat)

☐

I have prescribed Diastat for the student names above for use on an as-needed basis. In recognition of the possible need to promptly administer this drug while in attendance at Lovejoy Independent School District, when a trained medical professional may not be available, I acknowledge that circumstances may arise in which an unlicensed assistive personnel (UAP) who have been trained by a medical professional, including but not limited to emergency medical personnel, a physician and / or a registered nurse, may need to administer Diastat to the named student.

Physician Initials _____ **Parent Initials** _____

Physician Name

Physician Signature **Date**

Parent/Guardian Consent for Unlicensed Assistive Personnel to Administer Medication

I ☐ **do** / ☐ **do not** (check one) authorize the District to designate unlicensed assistive personnel (UAP) who have been trained by a medical professional, including but not limited to, emergency medical personnel, a physician and/or a registered nurse to administer Diastat to my child while in attendance at Lovejoy ISD or Lovejoy ISD related events (such as field trips and athletic events), when a trained medical professional may not be available. I understand that school related health services may not be provided to my student without my required consent, as outlined herein. **Parent initials** _____

Parent/Guardian Consent to Share Information and Picture

I ☐ **do** / ☐ **do not (**check one) authorize Lovejoy ISD to display a picture of my child and identify that this is a person with asthma. I understand that school staff that comes into contact with my child will be given information about my child that would assist them in an emergency situation. This may include but is not limited to: health office staff and substitutes, classroom teachers and aides, special subject teachers, substitute teachers, office staff, cafeteria staff and bus drivers. I understand that the reason for this is to enable school personnel to better prevent and respond to potential emergencies. This authorization is valid from the date signed for the remainder of the current school year. **Parent initials** _____

Parent/Guardian Authorization for School Staff to Communicate Health Information

I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my student's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other LISD form requesting for school health care services. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information. School-related health services described in this agreement shall not be provided to a student without the required consent of the parent/guardian, as outlined herein. **Parent initials** _____

Parent/Guardian Release of Claims Against District and Agreement to Indemnify

To the extent permitted under the law, on behalf of myself and the student, I release and agree to defend, indemnify, and hold harmless the District for all claims, damages, demands, or actions arising from, relating to or growing out of, directly or indirectly, the administration of Medication to the Student and/or the disclosure of Individually Identifiable Health Information. This release is to be construed as broadly as possible. It includes a release of claims against the District for its, joint or singular, sole or contributory, negligence or strict liability, including liability arising from the alleged violation of any statute (other than those which protect against discrimination based on race, age, sex, or other classification which has experienced historical discrimination), growing out of, relating to, or arising out of, directly or indirectly, the School Staff's administration of medication described in this document to the student and/or the disclosure of Individually Identifiable Health Information,, including but not limited to claims that School Staff negligently failed to recognize symptoms requiring the use of my child's Medication, misconstrued symptoms which it believed necessitated the use of my child's Medication, negligently administered or failure to administer Asthma Medication(s), and/or "over-disclosed" my child's Individually Identifiable Health Information.

Parent/Guardian Name _____ Phone _____

Parent/Guardian Signature_____ Date _____