



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

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

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 _____

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

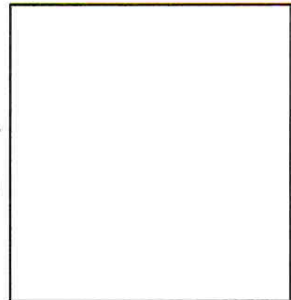
Does student have a Vagus Nerve Stimulator? Yes No If YES, describe magnet use: _____

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

Describe any special considerations or precautions: _____

Physician Signature _____ Date _____
 Parent/Guardian Signature _____ Date _____

**MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
MEDICATION ADMINISTRATION AUTHORIZATION FORM**



Child's Picture (Optional)

Child Care Program: _____

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to the facility.

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ Date of Birth: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____
(PRN=as needed)

If PRN, for what symptoms: _____

Possible side effects - Specify: _____

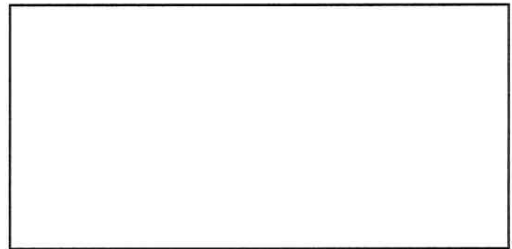
Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year (not to exceed 1 year)

Prescriber's Name/Title: _____
(Type or print)

Telephone: _____ FAX: _____

Address: _____

Prescriber's Signature: _____ Date: _____
(Original signature or signature stamp ONLY)



This space may used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the child named above, including the administration of medication at the facility. I/We understand that at the end of the authorized period, an adult must pick up the medication, otherwise it will be discarded.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's authorization: _____
Signature Date

Parental approval: _____
Signature Date

FACILITY RECEIPT AND REVIEW

Medication was received from: _____ Date: _____

Special Health Care Plan Received: YES NO

Medication was received by: _____
Signature of Person Receiving Medication and Reviewing the Form Date