Steger School District 194
Administration Center • 3753 Park Avenue • Steger, Illinois 60475
(708) 753-4300 *Phone* • (708) 755-9512 *Fax* • www.sd194.org

Seizure Action Plan

To ensure all students, staff, and stakeholders learn and grow together as a community

PATIENT INFORMATION SHEET / HOJA DE INFORMACIÓN DEL PACIENTE

Directions: Please check (✓) what happens (or happened) during your child's seizure and bring this sheet to your child's neurology appointment.

Direcciones: Por favor marque (✓) lo qué sucede (o sucedio) durante la convulsión de su niño(a) y traiga esta hoja con usted a la cita de neurología del niño.

DESCRIPTION OF SPELL OR SEIZURE / DESCRIPCIÓN DEL ATAQUE O CONVULSIÓN

Body / Cuerpo

- ☐ whole/ entero 
- ☐ right/ lado derecho 
- ☐ left lado izquierdo 
- ☐ can't tell no sabría decir ?

Movement/ Movimiento

- ☐ jerking/ espasmos 
- ☐ stiffness/ rigidez 
- ☐ jerking and stiffness/ espasmos y rigidez 
- ☐ can't tell no sabría decir ?

Eyes Ojos

- ☐ up/ ↑ en blanco 
- ☐ closed/ cerrados 
- ☐ right/ → a la derecha 
- ☐ left/ ← a la izquierda 
- ☐ stare/ mirada fija 
- ☐ stare and blink/ mirada fija y parpadeo 
- ☐ no change/ sin cambio 
- ☐ can't tell/ no sabría decir ?

Skin Color Color de piel

- ☐ blue/ morada 
- ☐ no change/ sin cambio 
- ☐ can't tell/ no sabría decir ?

Accident Accidente

- ☐ pee – pee orina 
- ☐ poop popo 
- ☐ none ninguno
- ☐ can't tell/ no sabría decir ?

Mouth Boca

- ☐ dry seca 
- ☐ drool babea 
- ☐ foam le sale espuma 
- ☐ bite tongue se muerde la lengua 
- ☐ can't tell/ no sabría decir ?

How Often / Frecuencia

- ☐ daily diariamente
- ☐ weekly semanalmente
- ☐ monthly mensualmente
- ☐ other otro : _____

AFTER SEIZURE OR SPELL / DESPUÉS DEL ATAQUE O CONVULSIÓN

- ☐ asleep/ se duerme 
- ☐ drowsy/ soñoliento 
- ☐ alert/ alerta 
- ☐ confused/ confundido 
- ☐ paralyzed paralizado 

PATIENT INFORMATION SHEET / HOJA DE INFORMACIÓN DEL PACIENTE

Directions: Please check (✓) the medications that your child takes and write in the daily dosage.
Direcciones: Por favor marque (✓) los medicamentos que su niño(a) toma y escriba la dosis diaria.

MEDICATION / MEDICAMENTOS

Drug name / Nombre del medicamento	How supplied / Forma del medicamento	Frequency / Frequencia for example: 3 times/day por ejemplo: 3 veces/día
Carbatrol (Carbmazepine)	☐ 200 mg ☐ 300 mg	
Depakene (Valproic Acid)	☐ 250 mg | Syrup 💧 ☐ 200 mg/ 5 mL	
Depakote (Divalproex Sodium)	☐ 125 mg ☐ 250 mg ☐ 500 mg ☐ 500 mg - **ER** **Sprinkle** ☐ 125 mg	
Dilantin (Phenytoin Sodium, Phenytoin)	☐ 30 mg ☐ 100 mg **Infatabs** ☐ 50 mg | **125** 💧 ☐ 125 mg / 5 mL	
Gabitril (Tiagabine HCL)	☐ 2 mg ☐ 4 mg ☐ 12 mg ☐ 16 mg ☐ 20 mg	
Keppra (Levetiracetam)	☐ 250 mg ☐ 500 mg ☐ 750 mg | Liquid 💧 ☐ 100 mg / mL	
Klonopin (Clonazepam)	☐ 0.5 mg ☐ 1mg ☐ 2 mg	
Lamictal (Lamotrigine)	☐ 25 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg **Chewables** ☐ 2 mg ☐ 5 mg ☐ 25 mg	
Neurontin (Gabapentin)	☐ 100 mg ☐ 300 mg ☐ 400 mg ☐ 600 mg ☐ 800 mg **Liquid** 💧 ☐ 250 mg / 5 mL	
Phenobarbital	☐ 15 mg ☐ 30 mg ☐ 60 mg ☐ 100 mg **Liquid** 💧 ☐ 20 mg / 5 mL	
Tegretol (Carbamazepine)	☐ 100 mg ☐ 200 mg ☐ 100 mg - **XR** ☐ 200 mg - **XR** ☐ 800 mg - **XR** **Liquid** 💧 ☐ 100 mg / 5 mL	
Topamax (Topiramate)	☐ 25 mg ☐ 100 mg ☐ 200 mg **Sprinkle** ☐ 15 mg ☐ 25 mg	
Trileptal (Oxcarbazepine)	☐ 150 mg ☐ 300mg ☐ 600 mg **Liquid** 💧 ☐ 300 mg/5 mL (60 mg/mL)	
Zarontin (Ethosuximide)	☐ 250 mg | Syrup 💧 ☐ 250 mg/ 5 mL	
Zonegran (Zonisamide)	☐ 100 mg	

QUESTIONS & CONCERNS / DUDAS Y PREGUNTAS

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EPILEPSY FOUNDATION

Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Contact Information

Student's Name	School Year	Date of Birth	
School	Grade	Classroom	
Parent/Guardian	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	Location	
Significant Medical History or Conditions			

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? _____
2. Seizure type(s)

Seizure Type	Length	Frequency	Description

3. What might trigger a seizure in your child? _____
4. Are there any warnings and/or behavior changes before the seizure occurs? ❒ YES ❒ NO
   If YES, please explain: _____
5. When was your child's last seizure? _____
6. Has there been any recent change in your child's seizure patterns? ❒ YES ❒ NO
   If YES, please explain: _____
7. How does your child react after a seizure is over? _____
8. How do other illnesses affect your child's seizure control? _____

Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? ❒ YES ❒ NO
    If YES, what process would you recommend for returning your child 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

Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? ❒ YES ❒ NO
    If YES, please explain:

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

Seizure Medication and Treatment Information

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and Time of Day Taken	Possible Side Effects

14. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to Do After Administration

** After 2nd or 3rd seizure, for cluster of seizure, etc.* *** Orally, under tongue, rectally, etc.*

15. What medication(s) will your child need to take during school hours? _____
16. Should any of these medications be administered in a special way? ❒ YES ❒ NO
    If YES, please explain: _____
17. Should any particular reaction be watched for? ❒ YES ❒ NO
    If YES, please explain: _____
18. What should be done when your child misses a dose? _____
19. Should the school have backup medication available to give your child for missed dose? ❒ YES ❒ NO
20. Do you wish to be called before backup medication is given for a missed dose? ❒ YES ❒ NO
21. Does your child have a Vagus Nerve Stimulator? ❒ YES ❒ NO
    If YES, please describe instructions for appropriate magnet use:

Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

❒ General health _____ ❒ Physical education (gym/sports) _____
❒ Physical functioning _____ ❒ Recess _____
❒ Learning _____ ❒ Field trips _____
❒ Behavior _____ ❒ Bus transportation _____
❒ Mood/coping _____ ❒ Other _____

General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? _____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ❒ YES ❒ NO

Dates _____
Updated _____

Parent/Guardian Signature _____ **Date** _____

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

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 _____

Epilepsy.com

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EPILEPSY FOUNDATION | END EPILEPSY

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MEDICATION AUTHORIZATION FORM

STUDENT NAME _____ BIRTHDATE _____

ADDRESS _____ PHONE NUMBER _____

SCHOOL _____ GRADE _____

EMERGENCY CONTACT NAME AND PHONE NUMBER _____

I. TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

I, _____, parent or guardian of _____ am primarily responsible for administering medication to my child. However, in a medical emergency or if necessary for the critical health and well-being of my child, I hereby authorize Steger School District 194, and its employees and agents, on my behalf and in my stead, to administer to my child or to allow my child to self-administer while under the supervision of the employees and agents of District 194, lawfully prescribed medication in the manner described below. I acknowledge that it may be necessary for the administration of medication to my child and treatment of my child's condition to be performed by an individual other than the school nurse and specifically consent to such practices. I will notify the school in writing if the medication is discontinued and will obtain a written order from the physician if the medication dosage or treatment is changed. I understand that this medication authorization is only effective for the _____ school year and will need to be renewed each subsequent school year.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against Steger School District 194, its employees and agents, arising out of the administration or self-administration of said medication, regardless of whether the authorization for self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice nurse. In addition, I agree to indemnify and hold harmless Steger School District 194, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorney's fees and costs expended in defense thereof, incurred or resulting from the administration or self-administration of said medication, except a claim based on willful or wanton conduct, regardless of whether the authorization or self-administration of medication was given by me, as the child's parent/guardian, or by my child's physician, physician's assistant, or advanced practice registered nurse.

Parent/Guardian Print Name _____ Date _____

Parent/Guardian Signature _____ Date _____

II. TO BE COMPLETED BY THE STUDENT'S LISCENSED PRESCRIBER

(Except for a Student Self-Administering Asthma Medication, see Section III Below)

Diagnosis: _____ Name of Medication: _____
Dosage: _____ Route of Administration: _____
Time/Circumstances when Medication Should be Administered: _____
Side Effects:_____
Date of Prescription: _____ Discontinuation Date: _____

TURN PAGE OVER & COMPLETE 2ND PAGE

Self-Administration of Epinephrine: _____Yes _____ No. The student listed above has a life threatening allergy that medically necessitates the immediate administration of epinephrine followed by emergency medical attention. I have determined that it is medically necessary for this child to carry an epinephrine auto-injector. The student has been instructed in the self-administration of the medication listed above and is capable of administering the medication independently. The student understands the need for the medication and the necessity to notify a staff member and the health office immediately following the self-administration of the epinephrine auto-injector.

Self-Administration of Diabetes Medication: _____ Yes _____ No. The student listed above has been diagnosed with diabetes. I have determined that it is medically necessary for this child to possess his/her diabetes medication and the equipment and supplies necessary to monitor and treat his/her diabetic condition pursuant to his/her Diabetes Care Plan. The student has been instructed in the self-administration of the medication listed above and use of his/her diabetes supplies and equipment and is capable of doing this independently. The student understands the need for the medication and the necessity of reporting to school personnel any unusual side effects.

I may be reached at the following phone number in the event of a reaction to the medication or an emergency.

_____	_____	
Phone Number of Physician	Signature of Physician	Date
_____	_____	
Address of Physician	Print Name of Physician	Date

III. FOR STUDENT SELF-ADMINISTERING ASTHMA MEDICATION ONLY

TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

Diagnosis: _____ Name of Medication: _____

Dosage: _____ Route of Administration: _____

Time/Circumstances when Medication Should be Administered: _____

Side Effects: _____

Date of Prescription: _____ Discontinuation Date: _____

Self-Administration of Asthma Medication: _____Yes _____ No. My child has been diagnosed with asthma and has been prescribed asthma medication by a qualified health care professional. I hereby authorize my child to carry his/her asthma medication and to self-administer his/her medication as prescribed by his/her physician. My child's physician has instructed my child in the self-administration of his/her medication and has indicated that my child is capable of doing this independently. My child understands the need for the medication and the necessity of reporting to school personnel any unusual side effects. I have provided the school an extra supply of his/her medication with a prescription label for use in the event that he/she forgets to bring his/her asthma medication to school on a particular day.

Parent/Guardian Print Name _____ Date _____

Parent/Guardian Signature _____ Date _____