FHUSD SEIZURE ACTION PLAN

McDowell Mtn.	Middle School	High School
480-664-5201	480-664-5402	480-664-5501

This plan should be completed by the student's Physician or Licensed Healthcare Provider and parent/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the FHUSD Registered Nurse, Health Aides, and other authorized personnel.

Parent/Guardian must complete pages 1 and 2 only. The Physician or Licensed Healthcare Provider must complete the remainder of the FHUSD Seizure ActionPlan.

_____
(Student's Name)

Effective Date: _____/_____/_____ Grade: _____ School Year _____---_____
Homeroom Teacher: _____
Birth Date: _____/_____/_____
Date of Diagnosis: ____/____/____

Student's Physician/Healthcare Provider:

_____

Telephone: (_____) _____-_____

Emergency Contact Information

Parent/Guardian #1: _____ Phone: (_____) _____-_____

Work Phone: (____) _____-_____ Ext# _____ Cell Phone: (_____) _____-_____

Parent/Guardian #2: _____ Phone: (_____) _____-_____

Work Phone: (____) _____-_____ Ext# _____ Cell Phone: (_____) _____-_____

Other Emergency Contact that can assume responsibility if parent/guardian cannot be reached:

_____
(Print name)

Relationship to student: _____ Phone: (_____) _____-_____

Notify parent/guardian or emergency contact in the following situations:
_____

Parent/Guardian please read and sign the Consent for Care on the next page of this form.

FHUSD Seizure Action Plan

Seizure Care Plan For:

_____
(Student's Name)

Parent/Guardian Consent for Care

(To be completed by Parent/Guardian)

I/we give permission to the FHUSD Registered Nurse, Health Aides, and other designated staff members to perform and carry out the Seizure Action Plan as outlined by

_____
(Physician/Licensed Healthcare Provider)

I consent to the release of the information contained in this Seizure Action Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I understand it is the responsibility of the parent/guardian to inform the physician or licensed healthcare provider and the school of any changes in the student's health status. I/we give permission for release of information to/from the FHUSD to/from the physician/licensed healthcare provider, for the 20_____-20_____ school year.
I/We agree that 911 will be called for any seizure activity lasting five minutes or longer and if unable to administer emergency medications and/or if CPR is started due to airway concerns.

_____
Parent/Guardian # 1 Date

_____
Parent/Guardian # 2 Date

Supplies to be kept at School **(All supplies listed below are to be provided by the parent/guardian.)**

Please list all equipment and Medications needed at school:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

The Next page is to be completed by the student's Physician/Licensed Healthcare Provider.

FHUSD Seizure Action Plan

Effective Date:_____ School year----_____---_____

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:_____

Parent/Guardian:_____Phone:_____Cell:_____

Treating Physician:_____Phone: _____

Significant medical history: _____

SEIZURE INFORMATION

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:_____

Student's reaction to seizure:

_____

_____

_____

Basic First Aid: Care and Comfort: (*Please describe basic first aid procedures)*

_____

_____

_____

Does the student need to leave the classroom after a seizure? YES NO

If 'YES', describe the process for returning the student to the classroom: _____

_____

EMERGENCY RESPONSE

A "Seizure Emergency" for this student is defined as : _____

_____

_____

SEIZURE EMERGENCY PROTOCOL AT SCHOOL

☐ Contact School Nurse at _____

☐ Call 911 for transport to _____

☐ Notify parent/guardian or emergency contact

☐ Notify doctor at this number_____

☐ Administer emergency medications as indicated below

☐ Other _____

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TREATMENT PROTOCOL DURING SCHOOL HOURS: *(Include daily and emergency medications)*

Medication	Dosage	Route	Time Given	Special instructions/ Side Effects

Does the student have a **Vagus Nerve Stimulator (VNS)**? YES NO
If 'YES' describe magnet use: _____

Special considerations and safety precautions: *(details regarding treatment during school day activities, classroom, sports, trips, etc.)*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Student's Physician/Licensed Healthcare Provider **Date**

_____ _____
Parent Signature **Date**