DUBLIN SCHOOLS

DUBLIN UNIFIED SCHOOL DISTRICT

EPILEPTIC/SEIZURE ACTION PLAN & CONSENT FORM

Last Name_____ First Name_____ DOB_____

School_____ Grade_____ School Year_____

TO BE COMPLETED BY PHYSICIAN

Seizure disorder related to the following diagnosis:_____

Type of seizure _____

Describe seizure activity_____

Frequency_____Duration_____

Date of last seizure_____ Weight_____

Loss of bowel or bladder control during seizure? _____

Does student experience an aura prior to seizure? If so, describe_____

Activity Restrictions_____

Special Considerations / Precautions_____

Call 911 for seizure lasting longer than _____ minutes, or_____

Date when emergency anti-seizure medication last administered: _____

If emergency anti-seizure medication is administered _____minutes (30 if left blank) prior to bussing, student will not be transported by bus unless authorized by parent/guardian.

MEDICATION PRESCRIBED AT SCHOOL- *Please list exact dose, ranges not accepted* **[ ] NO MEDICATIONS AT SCHOOL**

1) Medication _____ [ ] Generic OK

Dosage_____Time_____Route_____

If *as needed*, may repeat dose every_____ for symptoms_____

Adverse Reactions/ Special Instruction_____

2) Medication _____ [ ] Generic OK

Dosage_____Time_____Route_____

If *as needed*, may repeat dose every_____ for symptoms_____

Adverse Reactions/ Special Instruction_____

MEDICATIONS PRESCRIBED AT HOME

1) Medication _____ Dosage_____ Time_____ Route_____

2) Medication _____ Dosage_____ Time_____ Route_____

STAMP

PHYSICIAN SIGNATURE_____

DATE_____

EPILEPTIC/SEIZURE ACTION PLAN & CONSENT FORM

TO BE COMPLETED BY PARENT/GUARDIAN

EMERGENCY INFORMATION

STUDENT NAME_____ DOB_____

HOSPITAL_____ [ ] TAKE TO NEAREST HOSPITAL

PHYSICIAN NAME_____ PHONE_____

SPECIALIST NAME_____PHONE_____

EMERGENCY CONTACTS

1) NAME_____ RELATION_____
HOME#_____ CELL#_____ WORK#_____

2) NAME_____ RELATION_____
HOME#_____ CELL#_____ WORK#_____

3) NAME_____ RELATION_____
HOME#_____ CELL#_____ WORK#_____

AUTHORIZATION & CONSENT

- I authorize school personnel to assist with the above medication for my child according to physician instruction. I understand that trained, non-medical personnel may assist with this medication (Ed Code Sec 49423 and 49480).
- I understand this form must be renewed whenever the prescription changes and at the beginning of each school year.
- I understand that it is my responsibility to bring medication to health office in pharmacy labeled container and that medications must not be expired. All medications and supplies must have student's name clearly marked.
- I request that my child have above prescribed medications on field trips or in case of disaster**,** according to physician instruction. All over the counter medications must be included in prescription.
- I understand that by signing below I agree to release from liability the district, its officers, employees and agents for any loss, damage injury or liability of any kind to any person caused or arising from the acts, omissions or negligence of the district, its officers, employees and agents related to the assistance of medication to their child.
- I give consent for the District Nurse/School Personnel to communicate with authorized healthcare provider when necessary.

PARENT/GUARDIAN SIGNATURE_____ **DATE**_____