DUBLIN SCHOOLS

DUBLIN UNIFIED SCHOOL DISTRICT

EPILEPTIC/SEIZURE ACTION PLAN AND CONSENT

LAST NAME_____ FIRST NAME_____ DOB_____

SCHOOL_____GRADE_____ SCHOOL YEAR_____

TO BE COMPLETED BY PHYSICIAN

Student has a seizure disorder related to the following diagnosis:_____

Type of seizure experienced by student_____

Describe seizure activity_____

Frequency_____duration_____

Loss of bowel or bladder control during seizure?_____

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

Special Considerations / Precautions_____

Date of last seizure_____Weight_____

Date when emergency anti-seizure medication last administered:_____

MEDICATION PRESCRIBED AT SCHOOL- *Please list exact dose, ranges not accepted*

Medication _____ [ ] generic OK

Dosage_____ Time_____ Route_____

may repeat dose every_____ If as needed, list symptoms_____

_____

Potential adverse reactions and recommended mitigation actions:_____

_____

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

MEDICATIONS PRESCRIBED AT HOME FOR SEIZURE:

1) Medication _____ Dosage _____Time_____ Route_____

2) Medication _____ Dosage _____Time_____ Route_____

ACTIVITY RESTRICTIONS_____

ADDITIONAL INFORMATION_____

PHYSICIAN SIGNATURE_____ **Stamp**

DATE_____

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EPILEPTIC/SEIZURE ACTION PLAN & CONSENT

Last Name_____ First Name_____ DOB_____

TO BE COMPLETED BY PARENT/ GUARDIAN

EMERGENCY INFORMATION AND EMERGENCY CONTACTS

HOSPITAL_____ [ ] TAKE TO NEAREST HOSPITAL

PHYSICIAN NAME_____ PHONE_____

SPECIALIST NAME_____PHONE_____

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-licensed personnel may assist with this medication (Ed Code Sec 49423 and 49480) and may contact physician for clarification purposes.
- 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.
- While the school will make every effort to cooperate, the student must assume responsibility for coming to the office for medication.
- 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 School Nurse to communicate with authorized healthcare provider when necessary.

PARENT SIGNATURE_____ **DATE**_____

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Last Name_____ First Name_____

SIGNS OF SEIZURE ACTIVITY MAY INCLUDE:

• Staring / Rapid eye blinking	• Jerking movements of the arms and legs	• Stiffening of the body
• Loss of consciousness	• Breathing problems or breathing stops	• Loss of bowel or bladder control
• Nodding the head	• No response to noise / touch for brief periods	• Lip smacking / sucking / drooling
• Lips become blue	• Falling suddenly for no apparent reason	• Appearing confused or in a haze
• Flushed or pale skin tone	• Sweating	• Other:

IF SEIZURE ACTIVITY OCCURS, PROVIDE THE FOLLOWING MEASURES:

- Remain calm! No one can stop a seizure once it starts.
- Note time seizure activity started, part of body involved, type of movement, any injury, any breathing problems and skin color.
- Remain with student and call Health Office/Office for help.
- Clear room of other students and provide as much privacy as possible.
- Protect student's head from injury by placing folded blanket, towel or jacket under head.
- If possible, assist student to lie down on his/her side to keep airway clear from saliva and vomit.
- Do not place objects, food, drink or medication in mouth. This can cause aspirations, vomiting, broken teeth, or bitten tongue.
- Do not move student if injury has occurred.
- Call 911 if student's first seizure, you are alarmed with color or breathing of person, seizure lasts longer than_____ minutes.
- Stay with student at all times. Monitor color and breathing.
- Commence CPR/First aid if needed prior to EMS arrival.
- Notify Parent/Guardian.