SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION

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 _____

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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: _____

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EPILEPSY FOUNDATION

PROCEDURE FOR ADMINISTRATION OF MEDICATION

Prior to the School Nurses administering any medication, the health office shall have on file a **Medication Authorization Form** for the involved student, prepared by the student's attending licensed prescriber in compliance with the Manasquan School District's procedures, and signed by the student's parent/guardian.

Whenever possible, the parent/guardian should plan for medication to be administered at home, before and/or after school hours. In situations when a student's health could be compromised by not receiving medication during school hours, school district procedures must be followed for administering all medications.

1. Medication is defined as prescription or non-prescription (over the counter) drugs, including vitamins and supplements.

2. Administration of any medication requires both a physician's written order and signed parental permission.

3. Prescription medication must be in a pharmacy or physician labeled container. Over the counter medication must in its original container, sealed and unopened with the manufacturers label, clearly marked with the student's name.

4. It is the parent's/guardian's responsibility to bring the medication to school.

5. All medications to be taken during school hours will be kept in the School Nurse's office. It is the responsibility of the student to report to the nurse's office at the proper time to receive his/her medication. Students are allowed to carry and self-administer asthma medication or may use an Epinephrine Auto-Injector for anaphylaxis only after the school is notified, the student's parent/guardian and physician have signed the Medication Authorization Form, and it has been approved by our School Physician.

6. The parent/guardian must assume responsibility for informing the school, in writing, of any change in the student's health or change in medication. A physician's order must accompany any medication change.

7. Medication must be picked up by a parent/guardian on or before the last day of school. Medication not picked up will be discarded. Medication authorization is to be renewed, if necessary, every school year.

8. The school district cannot dispense medication without the completed Medication Authorization Form received, reviewed, and approved. It is wise to have it completed and mailed to the Office of the School Nurse in August for the upcoming school year.

Please note: Any missing information on the Medication Authorization Form will render it incomplete and it will be returned to the parent/guardian for correction, which may delay implementation of a pharmacological treatment plan

MANASQUAN SCHOOL DISTRICT

MEDICATION AUTHORIZATION FORM

*For any rescue medication

Student's Name: _____ Date of Birth: _____

Grade: _____ Gender: _____ Home Address: _____

Parent/Guardian Name: _____ Contact #: _____

I (we) request authorization and consent to have the school nurse administer medication to my child, while in school, as prescribed by our private physician. The Manasquan BOE hereby informs the parents of the above child that the district shall not incur liability as a result of any injury from self-medication. I hereby sign that I have read the above statement and will hold the MBOE harmless against any injury or claims that arise as a result of my child's self-administration.

Signed _____ Date_____

TO BE FILLED OUT BY PHYSICIAN

Diagnosis: _____Name of Medication: _____

Dosage, Form & Time: _____

If given prn, describe indications: _____ When can it be repeated? _____

Significant side effects include: _____

Is this medication for a life-threatening illness? _____ Is the child authorized to self- administer? ____

Has the child been trained by the healthcare provider? _____

Length of time this order is valid (may NOT exceed school year): _____

Physician's Signature: _____ Date: _____

Physician's Stamp:

APPROVAL OF SCHOOL PHYSICIAN

I have reviewed the above request and authorize the school nurse to administer the prescribed medication as ordered during school hours.

School Physician's Signature _____ Date: _____