SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Student Name: _____ Grade/Teacher: _____ Birth Date: _____

Address: _____ Phone: _____ Effective Date of Order and Plan: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

How to respond to a seizure (check all that apply) ☑

- D First aid – **Stay. Safe. Side.**
- D Give rescue therapy according to SAP
- D Notify emergency contact
- D Notify emergency contact at _____
- D Call 911 for transport to _____
- D Other _____

First aid for any seizure

- D **STAY** calm, keep calm, **begin timing seizure**
- D Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- D **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- D **STAY** until recovered from seizure
- D Swipe magnet for VNS
- D Write down what happens _____
- D Other _____

When to call 911

- D Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- D Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- D Difficulty breathing after seizure
- D Serious injury occurs or suspected, seizure in water

When to call your provider first

- D Change in seizure type, number or pattern
- D Person does not return to usual behavior (i.e., confused for a long period)
- D First time seizure that stops on its' own
- D 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: _____

Parent signature _____ Date _____

Licensed Healthcare Provider signature _____ Date _____

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OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
SEIZURE TREATMENT AUTHORIZATION

FOR USE WITH SEIZURE ACTION PLAN

Release and indemnification agreement

PLEASE READ INFORMATION AND PROCEDURES ON REVERSE SIDE

PART 1 TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request designated school personnel to administer prescribed anti-seizure (abortive) medication as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student if having a seizure, provided the designated school personnel comply with the Licensed Healthcare Provider (LHCP) or parent or guardian orders set forth in accordance with the provision of the Seizure Action Plan. I have read the procedures outlined below this form and assume responsibility as required.

Anti-Seizure Treatment □ Renewal □ New (If new, the first full dose must be given at home to assure that the student does not have a negative reaction.)

Last known seizure: Date_____ Time_____

Student Name (Last, First, Middle)	Date of Birth

Allergies	School	School Year

PART II SEE PAGE 1 OF SEIZURE ACTION PLAN – Complete by Parent/Guardian

☐ The anti-seizure medication will be given as noted and detailed on the attached Seizure Action Plan.
☐ Seizure Action Plan is attached.
☐ Anti-Seizure Treatment Medication is appropriately labeled.

Additional Notes:

_____	_____	_____	_____
Parent or Guardian Name (Print or Type)	Parent or Guardian (Signature)	Telephone	Date

PART III TO BE COMPLETED BY LICENSED NURSE OR TRAINED ADMINISTRATOR OF MEDICATION

Check ✓ as appropriate:
☐ Parts I and II above are completed including signature.
☐ Anti-Seizure Treatment Medication is appropriately labeled.

_____ Date any unused medication was collected by the parent or properly disposed. (Within one week after expiration of the physician order or on the last day of school).

_____	_____
Signature	Date

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PARENT INFORMATION ABOUT MEDICATION PROCEDURES

1. **In no case may any health, school, or staff member administer any medication outside the framework of the procedures outlined here in the *Office of Catholic Schools Policies and Guidelines* and *Virginia School Health Guidelines* manual**.
2. **Schools do NOT provide routine medications for student use**.
3. Medications should be taken at home whenever possible. The first dose of any new medication must be given at home to ensure the student does not have a negative reaction.
4. Medication forms are required for each Prescription and Over the Counter (OTC) medication administered in school.
5. **All** medication taken in school must have a parent/guardian signed authorization. Prescription medications, herbals and OTC medications taken for 4 or more consecutive days **also** require a licensed healthcare provider's (LHCP) written order. **No medication will be accepted by school personnel without the accompanying complete and appropriate medication authorization form**.
6. **The parent or guardian must transport medications to and from school.**
7. Medication must be kept in the school health office, or other principal approved location, during the school day. All medication will be stored in a locked cabinet or refrigerator, within a locked area, accessible only to authorized personnel, unless the student has prior written approval to self-carry a medication (inhaler, Epi-pen). If the student self carries, it is advised that a backup medication be kept in the clinic.
8. Parents/guardians are responsible for submitting a new medication authorization form to the school at the start of the school year and each time there is a change in the dosage or the time of medication administration.
9. A Licensed Health Care Provider (LHCP) may use office stationery, prescription pad or other appropriate documentation in lieu of completing the Seizure Action Plan. The following information written in lay language with no abbreviations must be included and attached to this medication administration form. Signed faxes are acceptable.
    a. Student name
    b. Date of Birth
    c. Diagnosis
    d. Signs or symptoms
    e. Name of medication to be given in school
    f. Exact dosage to be taken in school
    g. Route of medication
    h. Time and frequency to give medications, as well as exact time interval for additional dosages.
    i. Sequence in which two or more medications are to be administered
    j. Common side effects
    k. Duration of medication order or effective start and end dates
    l. LHCP's name, signature and telephone number
    m. Date of order
10. All prescription medications, including physician's samples, must be in their original containers and labeled by a LHCP or pharmacist. Medication must not exceed its expiration date.
11. All Over the Counter (OTC) medication must be in the original, small, sealed container with the name of the medication and expiration date clearly visible. Parents/guardians must label the original container of the OTC with:
    a. Name of student
    b. Exact dosage to be taken in school
    c. Frequency or time interval dosage is to be administered
12. The student is to come to the clinic or a predetermined location at the prescribed time to receive medication. Parents must develop a plan with the student to ensure compliance. Medication will be given no more than one half hour before or after the prescribed time.
13. **Students are NOT permitted to self medicate**. **The school does not assume responsibility for medication taken independently by the student.** Exceptions may be made on a case-by-case basis for students who demonstrate the capability to self-administer emergency life saving medications (e.g. inhaler, Epi-pen)
14. Within one week after expiration of the effective date on the order, or on the last day of school, the parent or guardian must personally collect any unused portion of the medication. Medications not claimed within that period will be destroyed.