Seizure Action Plan

Student Name: _____ **ID#** _____ **DOB**_____

School Year _____ **Grade / Teacher** _____ **Bus #** _____

Seizure Information

Seizure Type	Length	Frequency	Description
1.			
2.			
3.			

Seizure triggers or warning signs: _____

_____

Student's response after seizure: _____

_____

Basic Seizure First Aid

For All Seizures	For Generalized (Tonic-Clonic) Seizure	Seizure is an emergency when:
Stay calm and track time	Protect head	Generalized seizure lasts > 5 min.
Keep child safe	Keep airway open / watch breathing	Student has repeated seizures without regaining consciousness
Do not restrain	Turn child on side	Student is injured
Do not put anything in the mouth		Student is diabetic
Stay with child until fully conscious		Student is pregnant
Record seizure in log		This is a first time seizure
		Seizure occurs in water
		Student has breathing difficulty

Describe additional first aid procedures if different from those listed above: _____

_____

Does 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 child is defined as: _____

_____

Check all that apply and clarify below:

_____Call 911 after _____ minutes for transport to:_____

_____Contact School Nurse at: _____

_____Notify parent or emergency contact _____

_____Notify physician at: _____

_____Other: _____

Treatment Protocol During School Hours (include daily and emergency medications)

Daily Medication	Dosage and Time of Day Administered	Common Side Effects and Special Instructions
1.		
2.		
3.		

Emergency Medication	Dosage and Route	Common Side Effects and Special Instructions
1.		
2.		
3.		

Does the student have a VNS system? ___ YES ___ NO
Instructions: _____

Does the student require oxygen during a seizure? ___ YES ___ NO
Instructions: _____ liters/min. via _____ *(physician order required/O2 provided by parent)*

Special considerations and precautions regarding school activities (sports, trips, etc.):

_____

_____

Physician's Name_____ Phone # _____
Physician's Signature_____ Date _____

Emergency Contacts

Name	Telephone #	Relationship
Name	Telephone #	Relationship

Name_____ ID#_____ DOB _____ Gr./Tea./Sec._____ Date _____

Parent Consent / Seizure Action Plan

Parent/Guardian Consent for Unlicensed Assistive Personnel to Administer Medication

I **do / do not** (check one) authorize the District to designate unlicensed assistive personnel (UAP) who have been trained by a medical professional, including but not limited to, emergency medical personnel, a physician and/or a registered nurse to administer Diastat to my child while in attendance at Plano ISD or Plano ISD related events (such as field trips and athletic events), when a trained medical professional may not be available. I understand that school related health services may not be provided to my student without my required consent, as outlined herein. **Parent initials** _____

Parent/Guardian Consent to Share Information and Picture

I do / do not (check one) authorize Plano ISD to display a picture of my child and identify that this is a person with seizures. I understand that school staff that comes into contact with my child will be given information about my child that would assist them in an emergency situation. This may include but is not limited to: health office staff and substitutes, classroom teachers and aides, special subject teachers, substitute teachers, office staff, cafeteria staff and bus drivers. I understand that the reason for this is to enable school personnel to better prevent and respond to potential emergencies. This authorization is valid from the date signed for the remainder of the current school year. **Parent initials** _____

Parent/Guardian Authorization for School Staff to Communicate Health Information

I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my student's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other PISD form requesting for school health care services. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information. School-related health services described in this agreement shall not be provided to a student without the required consent of the parent/guardian, as outlined herein. **Parent initials** _____

Parent/Guardian Release of Claims Against District and Agreement to Indemnify

To the extent permitted under the law, on behalf of myself and the student, I release and agree to defend, indemnify, and hold harmless the District for all claims, damages, demands, or actions arising from, relating to or growing out of, directly or indirectly, the administration of Medication to the Student and/or the disclosure of Individually Identifiable Health Information. This release is to be construed as broadly as possible. It includes a release of claims against the District for its, joint or singular, sole or contributory, negligence or strict liability, including liability arising from the alleged violation of any statute (other than those which protect against discrimination based on race, age,

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sex, or other classification which has experienced historical discrimination), growing out of, relating to, or arising out of, directly or indirectly, the School Staff's administration of medication described in this document to the student and/or the disclosure of Individually Identifiable Health Information,, including but not limited to claims that School Staff negligently failed to recognize symptoms requiring the use of my child's Medication, misconstrued symptoms which it believed necessitated the use of my child's Medication, negligently administered or failed to administer Seizure Medication(s), and/or "over-disclosed" my child's Individually Identifiable Health Information.

The School Health Administrative Guidelines developed by the Plano Independent School District are subject to the Americans with Disabilities Act ("ADA"), 42 U.S.C. §12101, et seq.; Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 701, et seq.; and the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400 et seq.

Parent/Guardian Name

_____Phone:_____ **Parent/Guardian**

Signature_____ Date: _____

[1] 2015, 2017A, 2022A