Teamwork for Excellence

PLANO Independent School District

Seizure Action Plan

Student Name: _____ ID# _____ DOB_____

School Year _____ Grade / Teacher _____ Bus # _____

Significant Medical History:

Seizure Information

Seizure Type	Length	Frequency	Description
1.			
2.			
3.			

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 <u>daily</u> and <u>emergency</u> medications)

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

☐ Diastat____ mg rectally for seizure lasting more than _____minutes. *(parent provides medication)*

☐ Intranasal Versed _____mg intranasally for seizure lasting more than _____ *minutes* *(parent provides medication)*

☐ If seizure continues for more than _____ minutes after emergency medication has been administered, call 911.

☐ Oxygen at _____ liters/min. via _____during seizure.*(physician order required / 0_2 provided by parent)*

☐ VNS System (Instructions)_____

Seizure triggers or warning signs: _____

_____

_____

Student's response after seizure: _____

_____

_____

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

_____

_____

Physician's Name_____ Phone Number _____

Physician's Signature_____ Date _____

Emergency Contacts

Name	Telephone #	Relationship
Name	Telephone #	Relationship
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,

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: _____