NORRIS SCHOOL DISTRICT

SEIZURE ACTION PLAN

Physician to Complete

Name: _____ Birth Date: __/__/__ Grade: _____ School Site: □NMS □NES □WBE □ODE □VES
Parent/Guardian: _____ Phone Number: _____

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure Triggers or Warning Signs:_____

First Aid for any Seizure

- STAY Calm, keep calm, begin timing seizure
- Keep student 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
- Write down what happened

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 rescue therapy may be needed:

Name of medication and dosage prescribed

☐ Valtoco (Nasal diazepam) ___ mg ☐ Nayzilam (Nasal midazolam) ___ mg ☐ Diastat (Rectal diazepam) ___ mg

Indications for Use

☐ Status Epilepticus seizures lasting greater than _____ minutes

☐ Repetitive/Cluster seizures greater than _____ (number) in a row without full recovery of consciousness between seizures

☐ Other (Describe): _____

Directions for Use: _____
(E.g., route, dosage, timing for repeat doses, maximum dosage, and treatment frequency)

Contraindications: _____

Medication Side Effects: _____

Care after Seizure

What type of care is needed? (describe) _____

Does the student need to leave the classroom after any seizure activity? ☐Yes ☐No Describe: _____
If yes, describe the process for returning the student to class:_____

Special Instructions

First Responders: _____

Emergency Department: _____

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:_____

Authorized Health Care Provider Authorization in School Setting for

☐ Valtoco ☐ Nayzilam ☐ Diastat

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical healthcare procedures may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide the written authorization. Authorizations may be faxed.

Authorized Healthcare Provider Name: _____ Signature: _____ Date: _____

Phone: _____ Address: _____ City: _____ Zip: _____

Provider License Number: _____ Provider Stamp:

Parent Consent for Authorization for

☐ Valtoco ☐ Nayzilam ☐ Diastat

I, the undersigned, the parent/guardian of the above named student, request that the specialized physical healthcare procedure be administered to my child in accordance with state laws and regulations. I will:

1. Provide the necessary supplies and equipment
2. Notify the school nurse if there is a change in child's health status, or attending healthcare provider
3. Notify the school nurse immediately and provide new written consent/authorization for any changes
4. Provide new written consent/authorization yearly

I give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

Parent/Guardian (Print Name): _____ Signature: _____ Date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parent Authorization and Responsibility for Valtoco/Nayzilam/Diastat Administration in the School Setting

I, the undersigned parent/guardian of _____(name of student), request that the Norris School District will train school staff to give _____ (name of medication) to my child as stated in the physician authorization (see reverse side of this document) and in accordance with state laws and regulations including: California Education and Administration Code (SB161). I understand that the medication may only be administered by a licensed healthcare professional, trained unlicensed staff member, parent, or parent designee according to state laws and regulations. I agree to release and hold harmless the Norris School District, its officers, agents, and employees, for any injury, illness, or death which might occur as a result of assisting with the administration of the medication in accordance with the health care provider's direction.

I agree to the following:

_____ (initial) I will notify the school staff (including the teacher, bus driver, and school nurse) at the beginning of the school day if diazepam/ midazolam was administered to my child since the last day they were in school. I am aware that diazepam can only be given once every five days and midazolam can only be given once every three days or as ordered by the physician.

_____ (initial) I will notify the school nurse if there is any change in my child's seizure activity.

_____ (initial) I will maintain current phone numbers with the school nurse and school office in the event that 911 is called.

_____ (initial) I will provide the necessary medication, supplies, and equipment.

_____ (initial) I will come to the school whenever requested by the staff following administration of diazepam/midazolam.

I am aware of the following:

_____ (initial) 911 will be called whenever diazepam/midazolam is given.

_____ (initial) If my child has a seizure on the bus, the bus driver will pull over and call 911.

_____ (initial) My child will not be allowed to ride the school bus to school after the administration of diazepam/midazolam unless the student is awake and alert and it has been 4 or more hours since diazepam was administered.

I authorize the school nurse to communicate with the health care provider on matters related to my child's seizure disorder and authorized medication. I authorize the school nurse to train unlicensed staff to administer emergency medications in the absence of the school nurse. I understand that medication can only be administered to my child if the school has received ALL of the following:

1. Current California-authorized health care provider order
2. Parent/guardian signature
3. Pharmacy-labeled medication.

Parent/Guardian Signature_____Date_____