

NORTH HUNTERDON HIGH SCHOOL

**Ms. Cynthia Peck MSN, RN,
CSN**
Health Office



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APRN, PMHNP-BC, CSN**
Health Office

Student: _____ Grade: _____

Seizure Action Plan Date: _____

This form must be completed by the treating neurologist and submitted to the school nurse along with the Seizure Action Plan and medication forms by July 1st of each school year in preparation for the start of the school year.

Student has a prescription for emergency seizure medication during school hours: YES or NO

Student may ride the bus without a nurse present (911 will be called for any seizure activity): YES or NO

Student may participate in activities off-campus or outside of regular school hours without a school nurse present (911 will be called for any seizure activity): YES or NO

Seizure Action Plan is attached: YES or NO

Please indicate below as applicable to the student's plan of care:

Date of last neurological exam: _____ Date of last seizure: _____

Please Note: The parent is responsible for providing prescribed medication and informing the School District in advance of any busing or extracurricular activity to ensure that appropriate safety measures are in place.

Physician's Name: _____ Physician's Signature: _____

Reviewed by School Physician: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____

Consents:

I give my permission for the North Hunterdon School District, in an effort to provide for the health care of my child, to share medical information with other healthcare providers, school staff, and bus drivers as necessary. **Please initial all that apply:**

_____ Yes, please provide information naming my child and their seizure disorder to school staff.

_____ Yes, please provide information naming my child and their seizure disorder to bus drivers.

_____ No, I do not wish to have my child's name or medical information shared with anyone at this time.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____ Relationship to student: _____

Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Contact Information

Student's Name	School Year	Date of Birth	
School	Grade	Classroom	
Parent/Guardian	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	Location	
Significant Medical History or Conditions			

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? _____

2. Seizure type(s) _____

Seizure Type	Length	Frequency	Description

3. What might trigger a seizure in your child? _____

4. Are there any warnings and/or behavior changes before the seizure occurs? ☐ YES ☐ NO

If YES, please explain: _____

5. When was your child's last seizure? _____

6. Has there been any recent change in your child's seizure patterns? ☐ YES ☐ NO

If YES, please explain: _____

7. How does your child react after a seizure is over? _____

8. How do other illnesses affect your child's seizure control? _____

Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? ☐ YES ☐ NO

If YES, what process would you recommend for returning your child to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? ☐ YES ☐ NO

If YES, please explain:

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Seizure Medication and Treatment Information

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and Time of Day Taken	Possible Side Effects

14. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to Do After Administration

* After 2nd or 3rd seizure, for cluster of seizure, etc.

** Orally, under tongue, rectally, etc.

15. What medication(s) will your child need to take during school hours? _____

16. Should any of these medications be administered in a special way? ☐ YES ☐ NO

If YES, please explain: _____

17. Should any particular reaction be watched for? ☐ YES ☐ NO

If YES, please explain: _____

18. What should be done when your child misses a dose? _____

19. Should the school have backup medication available to give your child for missed dose? ☐ YES ☐ NO

20. Do you wish to be called before backup medication is given for a missed dose? ☐ YES ☐ NO

21. Does your child have a Vagus Nerve Stimulator? ☐ YES ☐ NO

If YES, please describe instructions for appropriate magnet use:

Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

- | | |
|---|--|
| ☐ General health _____ | ☐ Physical education (gym/sports) _____ |
| ☐ Physical functioning _____ | ☐ Recess _____ |
| ☐ Learning _____ | ☐ Field trips _____ |
| ☐ Behavior _____ | ☐ Bus transportation _____ |
| ☐ Mood/coping _____ | ☐ Other _____ |

General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? _____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ☐ YES ☐ NO

Dates _____

Updated _____

Parent/Guardian Signature _____ Date _____

Seizure Action Plan

Effective Date _____

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name	Date of Birth
Parent/Guardian	Phone _____ Cell _____
Other Emergency Contact	Phone _____ Cell _____
Treating Physician	Phone _____
Significant Medical History	

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ☐ Yes ☐ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol

(Check all that apply and clarify below)

- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify doctor
- ☐ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

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

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator**? ☐ Yes ☐ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ Date _____

Parent/Guardian Signature _____ Date _____