Oklahoma City Public Schools

SEIZURE ACTION PLAN

School Year:

School:	**Teacher:**	**Grade:**
Student Name		**Date of Birth**
Parent/Guardian	**Parent/Guardian Phone**	**Parent/Guardian Email**
Emergency Contact		**Emergency Contact Phone**

Seizure Information

Seizure Type	Length	Frequency	Description	Date of Last Seizure

Seizure triggers or warning signs:	Student response after a seizure:

Basic Seizure First Aid	**A seizure is generally considered an emergency when:**
• Stay calm & track time • Keep student safe • Do not restrain • Do not put anything in mouth • Stay with student until fully conscious • Record seizure in log **For tonic-clonic seizure:** • Protect head • Keep airway open/watch breathing • Turn student on side	• 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

Emergency Responses

A "seizure emergency" for this student is defined as:	**Seizure Emergency** • Call 911 for seizure lasting longer than _____ minutes • Notify parent or emergency contact & School Nurse • Administer emergency medications as indicated below • Other _____

Treatment Protocol During School Hours (Include daily & emergency medications)

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

Does student have a Vagus Nerve Stimulator? ☐ **Yes** ☐ **No** Describe magnet use:

Describe any special considerations or precautions:

*****A completed Authorization for Medication form must be completed and attached for medication at school*****

Physician/Licensed Health Provider _____ Date_____
Signature Phone _____

I give permission for school personnel to follow this plan, administer medication and care for my child following OKCPS Policy and contact my provider if necessary**. I understand this Seizure Action Plan must match the Authorization for Medication form completed by my Licensed Healthcare Provider.** I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I understand this plan is valid for this school year only and must be renewed at the beginning of each school year.

☐ I understand and acknowledge the above statement. ☐ I do not understand and acknowledge the above statement.

Parent/Guardian Signature_____ Date_____

Oklahoma City Public Schools
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

One Medication per Form

Authorization and request for the administration of medication at school for prescription and/or non-prescription medication.

Student_____ **Birthdate** _____ **Grade**_____ **School Year** _____
School_____ **Teacher**_____ **Date received** _____

- **TO BE COMPLETED BY THE LICENSED PHYSICIAN OR PRESCRIBER**

1. **Reason for medication** _____
2. **Name of medication** _____
3. **Dosage** _____
4. **Time to be administered** _____
5. **Duration (week, month, indefinite, etc.)** _____
6. **Side Effects:** ☐ **None Expected** ☐ **Specify** _____
   _____
7. **Form of medication/treatment: Tablet**____ **Liquid**____ **Inhaler**____ **Injection**____ **Nebulizer**____ **Other**_____
8. **Special storage requirements: None** _____ **Refrigerate** _____

_____ _____ _____
Licensed Prescriber Signature **Name (please print)** **Date**

_____ _____ _____
Address **Phone** **Fax**

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby request and give my permission for the above named school to administer the medication prescribed on this form. Prescription medication must have the pharmacy label attached and must match the written prescriber order. "Over the counter medication" must be in the original, unopened container. All medication must be brought to school by an adult. **Substances not approved by the FDA will not be stored nor administered by school personnel.** I further understand that I will be responsible for picking up any remaining medication at the end of the school year; medication will NOT be sent home with students. Any medication remaining after the school year has ended will be discarded utilizing proper procedure. The school nurse may consult with the prescriber regarding this prescription. Changes to the time and/or dosage of the medication require written authorization from the licensed prescriber and parent/guardian.

☐ **I understand and acknowledge the above statement.** ☐ **I do not understand and acknowledge the above statement.**

_____ _____
Parent/Guardian Signature **Date**

COMPLETE FOR SELF-ADMINISTRATION AND/OR SELF CARRY OF
ASTHMA, ANAPHYLAXIS, REPLACEMENT PANCREATIC ENZYME AND DIABETES MEDICATION ONLY

TO BE COMPLETED BY THE LICENSED PHYSICIAN/PRESCRIBER:

- **This student has been instructed and is capable and responsible to self-administer this medication: Yes** ____ **No** ____
- **This student may carry this medication on their person: Yes**____ **No**____

_____ _____
Licensed Prescriber Signature (Required) **Date**

- **TO BE COMPLETED BY THE PARENT/GUARDIAN:**

Authorization for Self-Administration and/or Self-Carry of Medication

THE SCHOOL DISTRICT SHALL INCUR NO LIABILITY AS A RESULT OF ANY INJURY ARISING FROM THE SELF-ADMINISTRATION AND/OR SELF-CARRY OF MEDICATION BY MY STUDENT/CHILD. PURSUANT TO OKLAHOMA LAW, I UNDERSTAND I AM *REQUIRED TO PROVIDE THE SCHOOL WITH AN EMERGENCY SUPPLY OF THE MEDICATION(S).*

_____ _____
Parent/Guardian Signature **Date**

I will not knowingly share my medication with another student.

_____ _____
Student Signature **Date**