NSG-205A
Rev. 01-2016

"We Inspire and Empower Learners"

NORTH ROYALTON CITY SCHOOLS

6579 Royalton Road
North Royalton, Ohio 44133

SEIZURE PACKET

Dear Parent/Guardian:

You have indicated that your child has had a seizure or has a seizure disorder. Please complete the attached **SCHOOL SEIZURE RECORD and SEIZURE ACTION PLAN** and return it as soon as possible to the school's clinic. The information will only be shared with the appropriate personnel. This information that you provide will help to ensure the health and safety of your child.

All forms must be completed and signed by your student's physician. Medications must be delivered to the school clinic by an adult, in original, labeled container.

If your child is no longer under the care of a physician for seizures, please handwrite a note and forward it to the school clinic as soon as possible. This will allow us to remove the medical alert from your child's record.

Please inform the school's nurse of any changes in your child's health condition or medication schedule.

Thank you,

Carolyn Baetjer RN

Carolyn Baetjer, R.N., BSN
District Health Coordinator
North Royalton City Schools
14709 Ridge Road
North Royalton, Ohio 44133
440.582.9067

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NSG-205B
Rev. 01-2016

SCHOOL SEIZURE RECORD

(To be Completed by Parent/Guardian)

Child's Name ____________________________________ Date ______________________________

Parent/Guardians(s) Name ____

Address ____ Home Phone _______________________

City ____ Alternate Phone ____________________

Physician Treating Child's Seizures____

Physician's Phone ______________________________

1. When was your child's first seizure? When was your child's most recent seizure?

2. Does your child have Epilepsy? Febrile Seizures? Or other type?

3. Does your child require a daily medication to help control the onset of seizures, if so please list name, dosage, and times given? Does your child require Diastat®?

4. What typically happens to your child during a seizure? (Example; rolls eyes, stares, etc…)

5. How long does the seizure usually last?

6. Can you identify what triggers the seizure (smell, light)? Can your child tell an adult of a potential onset of a seizure?

7. How frequently do the seizures occur?

8. How does your child react after a seizure?

9. Please list the action(s) you would like the school to take in the event of a seizure?

____

____

Parent/Guardian Signature _________________________________ Date ____________________

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NORTH ROYALTON CITY SCHOOLS
SEIZURE ACTION PLAN
CONFIDENTIAL

☐ Addendum Attached

__________ _____
Received by Date

This form is intended to be used as an addendum to a Section 504 plan, if necessary, or for those students who need seizure-related support in the school environment but are not eligible under Section 504. Use of this form for 504-eligible students does not eliminate the need for a 504 plan (DSE-504D).

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student ____ Birth date ____________

Mother/Guardian ______________________________ Home Tel ___________________

Cell ______________________ Work Tel ___________________

Father/Guardian ______________________________ Home Tel ___________________

Cell ______________________ Work Tel ___________________

Treating Physician ____ Tel _________________

Significant Medical History ____

Current Medications ________________________________ Allergies __________________________

SEIZURE EMERGENCY PROTOCOL:

☐ Diazepam rectal gel ______ mg. rectally PRN for seizure > _____minutes OR for ____ or more seizures in_______ hours. Following administration of Diazepam rectal gel, call parents to pick up child.
☐ Midazolam_____ mg. intranasal for seizure>_____minutes OR for ____or more seizures in ______hours. Call parent to pick up child following administration of Midazolam.
☐ Use Vagal Nerve Stimulator (VNS) magnet after _____minutes OR for ____or more seizures in _____hours.
☐ Other ____
☐ No rescue medication/treatment ordered

Call 911 if:

☐ Seizure does not stop by itself within ___________ minutes (No rescue medication/treatment ordered)
☐ Child does not start waking up within ___________ minutes after seizure is over (NO rescue med/treatment given)
☐ Child does not start waking up within ___________ minutes after seizure is over (AFTER rescue med/treatment given)

Following a seizure:

☐ Child should rest in clinic.
☐ Child may return to class (specify time frame ____)
☐ Notify parents immediately
☐ Other ____

Seizure Information – Student may experience some or all of the listed symptoms during a specific seizure.

Seizure Type(s)	*Description*	
☐ Absence	• Starting • Eye blinking	• Loss of awareness • Other ___________________________
☐ Simple partial	• Remains conscious • Distorted sense of smell, hearing sight	• Involuntary rhythmic jerking/twitching on one side • Other ___________________________
☐ Complex partial	• Confusion • Not fully responsive/unresponsive	• May appear fearful • Purposeless, repetitive movements
☐ Generalized tonic-clonic	• Convulsions • Stiffening • Breathing may be shallow • Lips or skin may have blush color	• Unconsciousness • Confusion, weariness, or belligerence when seizure ends • Other ___________________________

Seizure typically lasts ____________ minutes and returns to baseline in _____________minutes.

Triggers or warning signs

____

Call parents under the following circumstances

1. ____
2. ____

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 (grand Mal) seizure:
• Protect head • Keep airway open/watch breathing • Turn child on side

A Seizure is generally considered an EMERGENCY when
• A convulsive (tonic-clonic) seizure lasts longer than 5 minutes • Student has repeated seizures without regaining consciousness • Student has a first time seizure • Student is injured or has diabetes • Student has breathing difficulties • Student has a seizure in water

Restrictions/Special Considerations/Safety Precautions regarding school activities (sports, trips, etc)

____

____

PHYSICIAN SIGNATURE:	DATE:
PHYSICIAN NAME:	PHYSICIAN PHONE:

I, as parent/guardian of this student, give permission for school personnel to follow this plan, administer medication (if any) and care for my child and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Seizure Action Plan for my child. I also consent to the release of the information contained in this Seizure Action Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

____ ____________________
Parent/Guardian's Signature/Printed Date