Seizure Action Plan (SAP)

For a Student with an Active Seizure Disorder (Epilepsy) Diagnosis Per ORC 3313.7117 and 3313.713.

Ohio Department of Health

School Year: 20 / 20 SAP is effective only for the school year in which it is written.

A. STUDENT INFORMATION (This section completed and signed by Parent/Guardian)

Student Name:	**Date of Birth:**	**Grade:**	**School:**
Parent/Guardian:	**Parent/Guardian Phone:**		**Parent/Guardian Email:**
Treating Practitioner:	**Practitioner Phone:**		**Practitioner Fax:**
School Nurse/School Administrator:	**School Phone:**		**School Fax:**

As parent/guardian of the above-named student, I give permission for my student's healthcare provider to complete this Seizure Action Plan/Seizure Medication Protocol and share the information with the school nurse/school administrator. I understand the information contained in this plan will be shared with school staff per ORC 3313.7117.

- ☑ I authorize an employee of the school to administer seizure care and prescribed drugs listed in this plan.
- ☑ I understand that additional parent/prescriber signed statements will be necessary if the plan is changed.
- ☑ I also authorize the licensed health care professional to talk with the prescriber or pharmacist to clarify the Seizure Action Plan and/or drug(s) to be given.
- ☑ The Seizure Action Plan must be received by the school nurse, school administrator, or a school employee.
- ☑ I understand that a drug prescribed in this plan shall be provided in the container in which it was dispensed by the prescriber or a licensed pharmacist, to the school nurse or other designated person at the school who is authorized to administer the drug.

Parent/Guardian Name (print):	**Signature:**	**Date:**
Emergency Contact Name:	**Relationship:**	**Phone:**

B. SEIZURE CARE INFORMATION

Seizure Type/Description	Length	Frequency

Seizure triggers or warning signs:

Student specific information:

Does student need to leave the classroom after a seizure? ☐ **YES** ☐ **NO**
If YES, describe process for returning student to classroom:

SPECIAL CONSIDERATIONS:

Bus/Transportation:

Field Trips:

Sports:

Emergency situation such as "Lock Down":

Other:

Student Name:	Date of Birth:	School Year:

B. SEIZURE CARE INFORMATION (Continued) - Marks all behaviors that apply to student.

If you see this:

- ☐ Sudden cry or squeal.
- ☐ Loss of bowel or bladder control.
- ☐ Staring.
- ☐ Rhythmic eye movement.
- ☐ Lip smacking.
- ☐ Gurgling or grunting noises.
- ☐ Falling down.
- ☐ Rigidity or stiffness.
- ☐ Thrashing or jerking.
- ☐ Change in breathing.
- ☐ Blue color to lips.
- ☐ Froth from mouth.
- ☐ Loss of consciousness.
- ☐ Other (specify): _____

Do this:

- ☐ Stay calm and track time.
- ☐ Report symptoms and duration to parent.
- ☐ Keep student safe.
- ☐ Do not restrain.
- ☐ Protect head.
- ☐ Keep airway open/watch breathing.
- ☐ Turn student on side.
- ☐ Do not put anything in mouth.
- ☐ Do not give fluids or food during or immediately after seizure.
- ☐ Stay with student until fully conscious.
- ☐ Ensure symptoms resolve before student leaves classroom.
- ☐ Administer prescribed seizure rescue medication.
- ☐ Swipe VNS magnet.
  - Describe magnet use and location of implanted device on student: _____
- ☐ Other (specify): _____

Expected behavior after a seizure:

- ☐ Tiredness.
- ☐ Weakness.
- ☐ Sleeping, difficult to arouse.
- ☐ Somewhat confused.
- ☐ Regular breathing.
- ☐ Other (specify):_____

Follow-Up with:

- ☐ Notify school nurse or school administrator.
- ☐ Document observations.

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 is in water.
- ☐ Other (specify): _____

SEIZURE MEDICATION PROTOCOL DURING SCHOOL HOURS (Completed by Treating Practitioner):

Name of Medication/Dose (How Much)	Route (How to Give)	When to Give (Seizure Cluster, #, or Length)

LICENSED HEALTHCARE PROFESSIONAL AUTHORIZED TO PRESCRIBE:

Treating Practitioner Name (Print):	Signature:	Authorization Dates:
Phone Number:	Practice Address:	Start Date:_____ Stop Date:_____

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C. FOR SCHOOL USE ONLY (Completed by School Nurse or School Administrator).

EMERGENCY SEIZURE RESCUE MEDICATION AND SEIZURE DISORDER CARE:

Designated person(s) trained to give seizure disorder care, seizure medication, and/or use VNS magnet:

School Employee(s) (Specify Name):	Dates of Training (Required Every 2 Years):

Location of seizure rescue medication and/or VNS magnet:

SCHOOL NURSE OR SCHOOL ADMINISTRATOR:

Distribution of and training on the Seizure Action Plan (this form) to the school staff who (1) regularly interacts with the student; (2) has legitimate educational interest in the student or is responsible for direct supervision of the student; (3) is responsible for transportation of the student to and from school.

Specify Names:	Date SAP Received/Trained:
☐ Front Office/Administrative Staff	
☐ Teacher(s)/Classroom Staff	
☐ Transportation	
☐ Other(s):	

Seizure Action Plan (this form) is the responsibility of and maintained in the office of: ☐ School Nurse and/or ☐ School Administrator

School Nurse Signature:	Date:
School Administrator Signature:	**Date:**

ADDITIONAL INFORMATION FOR SCHOOL USE: