



Dear Parent(s),

Because each child with Epilepsy/Seizures presents a little differently and responds to different interventions, I would like to know from you how to respond to a seizure, specific to your child. This packet includes required forms to assist me in this endeavor.

- **The Seizure Action Plan**- This form is for me, and necessary staff, to use if your child has a seizure. This form will be sent with LCA staff members on field trips. A physician signature is required.
- **The Seizure Description Form**- The information documented on this form will assist me in training necessary faculty and staff members on how to recognize seizure activity regarding your student.
- **Medication form**- This form is for non-prescription and prescription medications and must be completed in its entirety. **Each medication, and child, requires a separate form.** All medication is to be stored in the clinic. Medications must be unexpired, unopened, and in the original container; and have a pharmacy label if it's a prescription medication. Please remember that all prescription medications must have a physician signature on the medication form. The clinic will not accept any medication unless accompanied with this completed form, and with the appropriate signatures.

Please have this paperwork completed over the summer, as it can take several weeks for physicians to complete them and prepare any required prescriptions. If you have any questions, please contact me.

Jamie Hartsell, RN, BSN

School Nurse

1101 Wesley Ave.

Xenia, OH 45385

937- 352-1655 (ph)

937-352-1641 (fax)

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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 _____

PATIENT INFORMATION SHEET / HOJA DE INFORMACIÓN DEL PACIENTE

Directions: Please check (✓) what happens (or happened) during your child's seizure and bring this sheet to your child's neurology appointment.

Direcciones: Por favor marque (✓) lo que sucede (o sucedió) durante la convulsión de su niño(a) y traiga esta hoja con usted a la cita de neurología del niño.

— DESCRIPTION OF SPELL OR SEIZURE / DESCRIPCIÓN DEL ATAQUE O CONVULSIÓN —

 Body / Cuerpo	<input type="checkbox"/> whole/ entero 	<input type="checkbox"/> right/ lado derecho 	<input type="checkbox"/> left lado izquierdo 	<input type="checkbox"/> can't tell no sabría decir ?	
 Movement/ Movimiento	<input type="checkbox"/> jerking/ espasmos 	<input type="checkbox"/> stiffness/ rigidez 	<input type="checkbox"/> jerking and stiffness/ espasmos y rigidez 	<input type="checkbox"/> can't tell no sabría decir ?	
 Eyes Ojos	<input type="checkbox"/> up/ ↑ en blanco 	<input type="checkbox"/> closed/ cerrados 	<input type="checkbox"/> right/ → a la derecha 	<input type="checkbox"/> left/ ← a la izquierda 	
<input type="checkbox"/> stare/ mirada fija 	<input type="checkbox"/> stare and blink/ mirada fija y parpadeo 	<input type="checkbox"/> no change/ sin cambio 	<input type="checkbox"/> can't tell/ no sabría decir ?		
 Skin Color Color de piel	<input type="checkbox"/> blue/ morada 	<input type="checkbox"/> no change/ sin cambio 	<input type="checkbox"/> can't tell/ no sabría decir ?		
 Accident Accidente	<input type="checkbox"/> pee – pee orina 	<input type="checkbox"/> poop popo 	<input type="checkbox"/> none ninguno	<input type="checkbox"/> can't tell/ no sabría decir ?	
 Mouth Boca	<input type="checkbox"/> dry seca 	<input type="checkbox"/> drool babea 	<input type="checkbox"/> foam le sale espuma 	<input type="checkbox"/> bite tongue se muerde la lengua 	<input type="checkbox"/> can't tell/ no sabría decir ?
 How Often / Frecuencia	<input type="checkbox"/> daily diariamente	<input type="checkbox"/> weekly semanalmente	<input type="checkbox"/> monthly mensualmente	<input type="checkbox"/> other : _____ otro	

— AFTER SEIZURE OR SPELL / DESPUÉS DEL ATAQUE O CONVULSIÓN —

<input type="checkbox"/> asleep/ se duerme 	<input type="checkbox"/> drowsy/ soñoliento 	<input type="checkbox"/> alert/ alerta 	<input type="checkbox"/> confused/ confundido 	<input type="checkbox"/> paralyzed paralizado 
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PATIENT INFORMATION SHEET / HOJA DE INFORMACIÓN DEL PACIENTE

Directions: Please check (✓) the medications that your child takes and write in the daily dosage.

Direcciones: Por favor marque (✓) los medicamentos que su niño(a) toma y escriba la dosis diaria.

— **MEDICATION / MEDICAMENTOS** —

Drug name / Nombre del medicamento	How supplied / Forma del medicamento	Frequency / Frecuencia <small>for example: 3 times/day por ejemplo: 3 veces/día</small>
Carbatrol (Carbamazepine)	<input type="checkbox"/> 200 mg <input type="checkbox"/> 300 mg	
Depakene (Valproic Acid)	<input type="checkbox"/> 250 mg Syrup ♣ <input type="checkbox"/> 200 mg / 5 mL	
Depakote (Divalproex Sodium)	<input type="checkbox"/> 125 mg <input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> 500 mg - ER Sprinkle ☼ <input type="checkbox"/> 125 mg	
Dilantin (Phenytoin Sodium, Phenytoin)	<input type="checkbox"/> 30 mg <input type="checkbox"/> 100 mg Infatabs <input type="checkbox"/> 50 mg 125 ♣ <input type="checkbox"/> 125 mg / 5 mL	
Gabitril (Tiagabine HCL)	<input type="checkbox"/> 2 mg <input type="checkbox"/> 4 mg <input type="checkbox"/> 12 mg <input type="checkbox"/> 16 mg <input type="checkbox"/> 20 mg	
Keppra (Levetiracetam)	<input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> 750 mg Liquid ♣ <input type="checkbox"/> 100 mg / mL	
Klonopin (Clonazepam)	<input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1mg <input type="checkbox"/> 2 mg	
Lamictal (Lamotrigine)	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg Chewables <input type="checkbox"/> 2 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 25 mg	
Neurontin (Gabapentin)	<input type="checkbox"/> 100 mg <input type="checkbox"/> 300 mg <input type="checkbox"/> 400 mg <input type="checkbox"/> 600 mg <input type="checkbox"/> 800 mg Liquid ♣ <input type="checkbox"/> 250 mg / 5 mL	
Phenobarbital	<input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 60 mg <input type="checkbox"/> 100 mg Liquid ♣ <input type="checkbox"/> 20 mg / 5 mL	
Tegretol (Carbamazepine)	<input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> 100 mg - XR <input type="checkbox"/> 200 mg - XR <input type="checkbox"/> 800 mg - XR Liquid ♣ <input type="checkbox"/> 100 mg / 5 mL	
Topamax (Topiramate)	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg Sprinkle ☼ <input type="checkbox"/> 15 mg <input type="checkbox"/> 25 mg	
Trileptal (Oxcarbazepine)	<input type="checkbox"/> 150 mg <input type="checkbox"/> 300mg <input type="checkbox"/> 600 mg Liquid ♣ <input type="checkbox"/> 300 mg/5 mL (60 mg/mL)	
Zarontin (Ethosuximide)	<input type="checkbox"/> 250 mg Syrup ♣ <input type="checkbox"/> 250 mg / 5 mL	
Zonegran (Zonisamide)	<input type="checkbox"/> 100 mg	

— **QUESTIONS & CONCERNS / DUDAS Y PREGUNTAS** —

Legacy Christian Academy School Medication Administration Authorization Form Prescription or Non-Prescription Medication

Legacy Christian Academy Clinic
1101 Wesley Ave., Xenia OH 45385
Phone: 937-352-1655
Fax: 937-352-1641

Student's Name: * Only one student name per form*		Grade:
Address:		Phone
City:	State:	Zip:
Medication Name: *Only list one medication per form*	Dosage:	
Time/Frequency of administration:	Special instructions for administration or storage:	
Date administration is to begin:	Date to cease:	
Severe adverse reactions that should be reported to the physician:		
Required for prescription medications only		
Physician's name and address:		
One or more of physician's phone number:		
Phone:	Phone:	Fax:
Physician's signature:		Date:

This form must be completed entirely in order for medication to be administered.

All medications must be in the original container with label intact.

All prescription medications need to have the dosing information completed and signed by a physician.

Any changes to prescription medication dosage or administration need to be signed by a physician.

Emergency Medication Self Carry/Administration Authorization/Approval

Self carry/administration of emergency medication may be authorized by the prescriber and must be approved by the school nurse according to the State Medication Policy.

Prescriber authorization for self carry/administration of emergency medication: _____

School Nurse approval for self carry/self administration of emergency medication: _____

Parent/Guardian Authorization

I/We request designated school personnel to administer the prescription medication as prescribed by the above prescriber. I/We request the designated school personnel or volunteer nurse to administer the non-prescription medication as directed above. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We authorize the school nurse to communicate with the health care provider if needed.

Parent/Guardian Signature _____ Date: _____
Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____