Seizure Questionnaire – **TO BE COMPLETED BY PARENT(S)**

Student's name:____ Program:__________________________

At what age was your student diagnosed with seizures?___________________________________

Please list the type of seizures your student is affected by:____

When was your student's most recent seizure?____

Does your student take medications to control seizures? **YES** **NO**

If so, please list the medication and dose below. Please include any rescue medications that your provider has prescribed.

____

____

Will your student need to keep/take medication at school? (This includes rescue medications.) **YES** **NO**
If yes, please complete the attached Medication Authorization Form and provide medications to the clinic ASAP!

Does your student have a Vagus Nerve Stimulator? **YES** **NO**

What might trigger a seizure?____

____

Are there any warning signs and/or behavior changes before the seizure occurs? **YES** **NO**

If yes, please explain:____

____

When possible, would you like your student be pulled from the classroom prior to fire drills? **YES** **NO**

Please include any additional information you would like us to be aware of pertaining to your student's medical condition(s).____

____

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I consent to the release of information contained in my student's Seizure Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the School Nurse to communicate with my child's physician/healthcare provider relating to seizure management.

Parent signature/Date:____

School Nurse signature/Date:____

Medina County Career Center
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:______________

Treating Physician:______________________ Phone: ____________

Significant medical history:____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:__________________________________

Student's reaction to 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 (grand mal) 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
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other______________________________

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

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication

____

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use_____________________________

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

Physician Signature:______________________________ **Date:**____________

Parent Signature:________________________________ **Date:**____________

Fax: (330)725-5870, PH: (330)725-8461

Authorization for the Administration of Prescription Medication By School Personnel

As required by Section 3313.713 Ohio revised Code

Student Name ______________________ Date of Birth ______________________

Address ______________________

Student's Program ______________________ Grade ______________________

PARENT/GUARDIAN SECTION

Please review the following steps required for permission of school personnel to administer any medication to your child and sign this section:

1. Both the parent (top section) and the licensed prescriber (bottom section) must complete this form.
2. Medication must be provided in the student's labeled prescription bottle. (The pharmacy may provide an extra bottle for long-term medication.) The prescription label must match the instructions from the prescriber. If it is a non-prescription medication, it must be in the original container. Medication must not be expired.
3. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability ***foreseeable or unforeseeable*** for damages or injury resulting directly or indirectly from this authorization.
4. New forms must be submitted when there is a change in the original forms. (i.e. dose, time).
5. At the end of the school year, the parent should pick up any unused medication. Otherwise, the Career Center will dispose of any unused portions.

I request that medication be administered to my son/daughter according to the directions of the licensed prescriber in the following section. I also authorize the exchange of information between the health care provider and the school regarding this medication order when deemed necessary by school personnel.

Signature of Parent ______________________ Date ______________________

Home Phone Number ______________________ Work or Cell Phone number ______________________

LICENSED PRESCRIBER SECTION

I verify that this medication must be taken by: ______________________
Student

Diagnosis (reason) for which medication is prescribed:

____

Medication ______________________ Strength ______________________ Dose ______________________

Time Medication to be taken ______________________ Administration Start Date ______________________ Administration End Date ______________________

Instructions or precautions, including possible side effects and storage:

____

Licensed prescriber signature ______________________ Licensed prescriber printed name ______________________ Date ______________________

Student to self-carry and self-administer Epi-Pen: ______________________ Licensed prescriber Initials ______________________ Date