Springs CHARTER SCHOOLS
HEALTH SERVICES DEPARTMENT

Seizure Action Plan

Effective Date: _____

Student Name: _____ DOB: _____ Grade: _____

Site/Program: _____

MEDICATION(S) WILL NOT BE ADMINISTERED WITHOUT THE REQUIRED SIGNATURES

Parents/Guardian Information:	Relationship:	Phone Number(s):
1)		
2)		

I authorize school staff to give my child the prescribed medication and release Springs Charter Schools and staff from liability under California law. I allow the school nurse or trained staff to administer it and permit necessary health information to be shared with my child's provider.

Parent/Guardian Signature: _____ Date: _____

This portion to be completed by the Physician

SEIZURE INFORMATION			
Seizure Type	**Length**	**Frequency**	**Description**
Seizure triggers or warning signs:		Student's response after a seizure:	

Student may Self-Administer and Self-Carry (if applicable) ☐ Yes ☐ No ☐ NA (if **yes**, complete page 2) ****Only applies if a student has a 1:1**
Does the student need to leave the classroom after a seizure? ☐ Yes ☐ No
If YES, describe process for returning student to classroom:_____

First Aid for any Seizure	**When to call 911**
➢ **STAY** calm, keep calm, begin timing the seizure ➢ Keep me **SAFE** – remove harmful objects, don't restrain, protect head ➢ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth ➢ **STAY** until recovered from seizure ➢ Swipe magnet for VNS	➢ Seizure lasting more than 5 minutes (give rescue medication) ➢ Seizure with loss of consciousness longer than 5 minutes and not responding to rescue medication if available ➢ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available ➢ Difficulty breathing after a seizure ➢ Serious injury occurs or is suspected, seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Medication	Dose	Method of Administration	Time to be given

Does the student have a Vagus Nerve Stimulator? ☐ Yes ☐ No
If YES, describe magnet use: _____
Special Considerations and Precautions (regarding school activities, sports, trips, etc.) ☐ Yes ☐ No
Describe any special considerations or precautions: _____

Physician/HCP Name (printed): _____ NPI: _____

Physician/HCP Signature: _____ License Number:_____ Date: _____

Return Fax: 951-489-0494 / Email: school.nurse@springscs.org

Springs CHARTER SCHOOLS
HEALTH SERVICES DEPARTMENT

Authorization for Self-Administered Medication at School

Student Name: _____ DOB: _____ Grade: _____

Site/Program: _____ Teacher: _____

In order for your child to carry a self-administered medication, the following conditions must be understood and agreed upon by both the student and parent/guardian: The student may use the prescribed medication as needed and as directed by their physician. The physician's signature confirms that the student has been properly instructed on its use. The medication must be clearly labeled with the student's name. **Both the Seizure Action Plan and this document** must be signed by the parent/guardian and kept on file at the school before the student is permitted to carry the medication.

NO DIRECT MONITORING will be conducted by the school staff for self-carry medications. The student is responsible for the safe handling and self-administration of medication. The student is responsible for notifying school staff if he/she self-administer any emergency medication (i.e., epinephrine). *****Exceptions may apply for students with 1:1 monitoring while on campus. MD signature is a recommendation; however, the campus RN has the final decision to allow self-carry medications.**

Parents are responsible for promptly notifying the school of any changes to their child's health status, physician, or prescribed medications. Any change in medical procedures must be submitted in writing by the treating physician. The district is not responsible for risks associated with improper handling of medication, including overuse, incorrect administration, breakage, theft, loss, sharing, misuse, or careless storage. If a student engages in behaviors that increase safety risks to themselves or others, the current protocol may be re-evaluated.

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I authorize my child to carry the prescribed medication and release the school district and staff from liability for any adverse reaction resulting from self-administration during school hours..

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY THE STUDENT

I have been instructed in the proper use of my medication and will take it as prescribed. I understand that misuse may lead to disciplinary action by my School/District.

Student's Signature: _____ Date: _____

PHYSICIAN TO COMPLETE

The child's well-being is in jeopardy unless this medication is carried on his/her person. Therefore, I request that he/she be permitted to carry the medication at school. The student has been instructed in proper medication use and is able to self-administer responsibly, understanding its purpose, method, and frequency.

Medication	Dose	Method of Administration	Time to be given	Frequency

Physician/HCP Name (printed): _____ NPI: _____

Physician/HCP Signature: _____ License Number:_____ Date: _____

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