*Return completed form to:*
*Jefferson County Public Schools,*
*Health Services Department, LAM Building*
*4309 Bishop Lane, Louisville, KY 40218*
*Telephone # (502) 485-3387*
*Fax # (502) 485-3670*

# JEFFERSON COUNTY PUBLIC SCHOOL
# SCHOOL HEALTH PLAN
# SEIZURE ACTION PLAN

**School Year:**

**DO NOT WRITE IN THIS AREA**
0044612872

## PART A Parent / Guardian: Complete Items 1 - 11 *(Padre/madre/tutor: complete la información en los espacios 1 al 11)*

**1) Student ID#** *(Numero de estudiante)* | **2) Student's Last Name** *(Apellido)* | **3) Student's First Name** *(Nombre del estudiante)* | **4) Date of Birth** *(Fecha de nacimiento)*

**5) School** *(Escuela)* | **6) Grade** *(Grado)*

**Parent/Guardian Name & Contact Information** ***(Nombre & Información del contacto)***

**7)** Name *(Nombre)* | **8)** Phone Number *(Teléfono)* ( ) - | **9)** Mailing Address, City, State, Zip *(Dirección posta, ciudad, estado, código postal)*

**10)** Emergency Contact (Contacto de emergencia y Teléfono) ( ) -

**11) Note to parent/guardian:** Signing this form shall release the Jefferson County Board of Education and its employees from liability of any nature that might result from this plan of action. This form shall not relieve the liability of the school or its employees for their own negligence. Also, I hereby give permission for the healthcare provider completing and signing this form to exchange information with JCPS staff regarding this health condition. I acknowledge and agree when I authorize my child to attend a school sponsored field trip these medications and/or health services may also be provided by a licensed volunteer.
**Parents please note: In order for medications to be administered, parent must complete an "Authorization for Medication" form for each medication needed at school.**

**PARENT/GUARDIAN Signature** X | **TELEPHONE NUMBER** ( ) - | **DATE**

## PART B COMPLETED BY THE HEALTHCARE PROVIDER ONLY: Complete Items 12 – 15
(12 al 15 - Esta sección para ser completada por el médico solamente.)

**12) Seizure Information**

| Seizure Type | Length | Frequency | Description |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Seizure Triggers/Warning Signs:

Student's response after a seizure:

**13) Basic First Aid: Care & Comfort**

- Stay calm & track time
- Keep student safe (protect head, keep airway open/watch breathing, turn on side)
- Do not restrain or put anything in mouth
- Stay with student until fully conscious
- Document seizure findings

**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 seizure for the first time

**Emergency Protocol:**

- Time seizure
- Ease student to floor if upright; If in wheelchair, secure chair & protect head
- Remove hazards; place student on their side
- Use emergency meds/treatments if ordered based on plan
- Call designated 1st-aid/CPR staff. Call 911 if over 5 mins or emergency meds used

If an emergency seizure medication is administered and a nurse is available in the building to monitor the stable student, the nurse may observe the student until the parent/guardian arrives. If unable to reach parent/guardian within 30 minutes of administration and/or they are unable to get to the school within one hour of administering, EMS will be called.

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

| ER Med. | Medication | Dosage & Time of Day Given | Common Side Effects & Special Instructions |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Does student have a VNS (Vagus Nerve Stimulator)? If yes, describe magnet use below:

☐ YES ☐ NO

**15) Healthcare Provider Information** Form **must** be signed by a Healthcare Provider **and** parent/guardian

Healthcare Provider Signature X | Date

Healthcare Provider Printed Name

Medical Office Stamp (required for processing)