

Seizure Action Plan

Room #

These forms must be updated by the child's physician every 6 months.

Basic Seizure First Aid	A seizure is generally considered an emergency when	For Tonic-Clonic Seizure
<ul style="list-style-type: none"> • Stay calm & track time • Keep child safe • Do not restrain • Do not put anything in mouth • Stay w/ child until fully conscious • Record seizure in a log 	<ul style="list-style-type: none"> • Convulsive (tonic-clonic) seizure lasts longer than 5 minutes • Student has repeat seizures without regaining consciousness • Student is injured or has diabetes • Students has a first-time seizure • Student has breathing difficulties • Student has a seizure in water 	<ul style="list-style-type: none"> • Protect Head • Keep airway open • Turn child on side

Student's Name	Date of Birth
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Parent/Guardian	Phone	Cell
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Other Emerg. Contact	Phone	Cell
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Treating Physician	Phone
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Significant Medical History

Seizure Type	Length	Frequency	Description	Time

Basic First Aid & Comfort: *Please describe basic first aid procedures*

Emergency Response

<i>A seizure emergency for this student is defined as:</i>	Seizure Emergency Protocol (Check all that apply)		
		Contact School Nurse at:	
		Call 911 for transport to:	
		Notify Parents or Emergency Contact	
		Administer emergency medication as indicated below	
		Notify doctor	
	Other:		

Emerg. Med	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions	
	Tylenol _____ml	Infant (or) Children's		
	or Generic	Time of Day:		
	Give 1st	Give 2nd	Give Only	Do Not Give at all
	Motrin _____ml	Infant (or) Children's		
	or Generic	Time of Day:		
	Give 1st	Give 2nd	Give Only	Do Not Give at all
		Time of Day:		
	Give 1st	Give 2nd		Give Only

Does student have a Vagus Nerve Stimulator	Yes	No	If YES, describe magnet use:
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Special Considerations and Precautions: (regarding school activities, sports, playground, etc.)

Describe:

Parent/Guardian Signature	Date	Physician Signature	Date
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For Office Use



CCDC HEALTH SERVICES
A Ministry of Calvary Church

CCDC MEDICATION/CARE AUTHORIZATION AND RELEASE

Child's Name: _____ Age: _____

For children with Food or Non-Food allergies, please check. I acknowledge that Calvary Church, including Calvary Child Development Center, not an allergen-free facility that CCDC cannot guarantee my child will not be exposed notwithstanding awareness of his/her allergies, and he/she may be exposed to an allergen while on-site at CCDC.

For All Medical Action Plans (Food Allergy, Non-Food Allergy, Seizure, or Asthma)

I hereby give permission for my child, while present at CCDC, to receive medication in accordance with the Medical Action Plan for my child or as otherwise indicated below, as prescribed by a licensed physician. I hereby authorize CCDC, including its directors, staff and volunteers, to administer medication and to provide or arrange for medical care in accordance with the Medical Action Plan or as indicated below.

For myself and for my child, I release and discharge CCDC, Calvary, its officers, elders, employees, volunteers or other agents from all claims and liability for any loss or injury that may occur in the future as a result of exposure to allergens and any medications or care provided under this authorization and release. I further agree to reimburse, indemnify and hold Calvary and CCDC harmless from any and all costs, claims and liabilities associated with providing or arranging medical care for my child.

Parent/Guardian: _____ Signature: _____ Date: _____

Address: _____ Phone: _____

Medical Need	Medication	Method of Application	Dosage	Prescribed By

Signature of Health Care Provider:

(Doctor, Nurse Practitioner, Physician's Assistant)

Address: _____

Phone: _____

Date: _____

(Signature Stamp Required)