

**RIVER FALLS SCHOOL DISTRICT  
SCHOOL EPILEPSY/SEIZURE ACTION PLAN  
School Year: \_\_\_\_\_**

A prescription medication may be administered to a student in compliance with the written instruction of a practitioner and written consent from the student's parent/guardian. All prescription medications need to come to school in the original pharmacy-labeled package; and the package specifies the name of the student, the name of the prescriber; the name of the prescription drug, the dose; the effective date, and the directions in a legible format. The Health Office staff cannot administer expired medication and medication that *is* not in its original pharmacy-labeled package. The Health Office requires a written note from parent/guardian on discontinued medication. The Seizure Action Plan Form needs to be renewed each school year and if medication orders change during the school year.

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Mother Cell: \_\_\_\_\_ Father Cell: \_\_\_\_\_

Mother Work: \_\_\_\_\_ Father Work: \_\_\_\_\_

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**To Be Completed by Practitioner**

**SEIZURE INFORMATION:**

<i>Seizure Type</i>	<i>Length</i>	<i>Frequenc y</i>	<i>Description</i>
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Date/Age of student's first seizure: \_\_\_\_\_

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:

\_\_\_\_\_

\_\_\_\_\_

**CURRENT MEDICATION/TREATMENT PROTOCOL**

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

**EMERGENCY RESPONSE:**

A "seizure emergency" for this student is defined as: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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

**Seizure Emergency Protocol: (Check all that apply and clarify below)**

- Follow Basic Seizure First Aide as listed above
- Notify parent or emergency contact
- Call 911
- Administer emergency medications as indicated below
- Other \_\_\_\_\_

**EMERGENCY MEDICATION PROTOCOL**

Emergency Medication	Dosage & Time to Administer	Common Side Effects & Special Instructions

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

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Practitioner's signature: \_\_\_\_\_ Print name: \_\_\_\_\_

Date: \_\_\_\_\_ Address: \_\_\_\_\_ Phone \_\_\_\_\_

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I request that the above mentioned medication be given as prescribed by the practitioner to my child. I will keep the school district aware of any changes in medication profile or health concern of my child, I give my medical provider and River Falls School District permission to release and obtain information from each other as necessary to administer medication. I understand that the medication will be disposed of if not picked up within one week following termination of the order; or one week beyond the close of school.

Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_