Tempe Union High School District
Request for Medical Documentation – Seizures

Student's Name:
Student ID:

Date:

Dear Parent/Guardian,

Attached are forms for your student for the upcoming school year. New forms are required each year. The forms attached are:

1. Seizure Disorder History Form to be filled out by parent
2. Seizure Care Plan to be filled out by licensed health care provider
3. Consent for Medication Administration Form, to be filled out by the parent and the licensed health care provider.

Please complete the Consent for Medication Administration form if your student requires over the counter or prescription medication during the school day.

If you would like to request a meeting with the nurse regarding your child's health care needs, please let me know and I will arrange a meeting.

Feel free to contact your school health office with any questions.

Thank you,

Tempe Union High School District
SEIZURE DISORDER HISTORY

Instructions: Complete and return form to the school health office

Student Name _____ DOB _____
ID Number _____ Date _____

1. What type of seizures does your student have? Please describe your student's typical seizure.

_____

2. How often do seizures occur? How long do the seizures normally last?

_____

3. When was your student's last seizure?

_____

4. Has your student ever stopped breathing during a seizure? ☐ No ☐ Yes If yes, how is that handled?

_____

5. Is there anything that seems to trigger a seizure? ☐ No ☐ Yes If yes, explain.

_____

6. Does your student experience an aura before a seizure? ☐ No ☐ Yes If yes, explain.

_____

7. Does your student require the use of any protective equipment (i.e. helmet)? ☐ No ☐ Yes If yes, explain.

_____

8. How are your student's seizures treated (daily medication, rescue medication, VNS)?

_____

9. Is your student currently taking medication to control their seizures? ☐ No ☐ Yes If yes, list name, dosage, and how often your student takes this medication. **If the medication is to be kept in the health office, Consent for Medication form must be on file.**

_____

Parent/Guardian Signature: _____ Date: _____

TEMPE UNION HIGH SCHOOL DISTRICT
Consent for Giving Prescription and Non-Prescription Medications at School
School Year _____ to _____

Student Name _____

School _____ **Student ID** _____

Medication must be delivered to school in the original container with the label intact.

The medication is to be given in the following manner:

Name of Medication: _____

Strength of Medication: _____

Amount to be Given: _____

Time of Administration at School: _____

Route of Administration (by mouth, etc.):_____

Comments and/or Instructions: _____

Reason for Medication: _____

Date Medication is to be discontinued: _____

☐ Student may self-carry and self-administer their medication (**Valid only for diabetes, asthma, and anaphylactic reactions. Students may not carry any other medications.**)

Healthcare Provider Name: _____ **Phone No.** _____
(Please print)

_____
Healthcare Provider Signature **Date**

I hereby request and my consent for the School Nurse or person designated by the School Administration to give my child medication prescribed by the below listed licensed health care provider. **I acknowledge that it may be necessary for the assistance in administration of medication to my child to be performed by an individual other than a nurse, and specifically consent to such practice.**

I understand the law provides that there shall be no liability for civil damages as a result of the assistance in administration of such medication and/or treatment where the person assisting in the administration of such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I understand my child's medication is to be presented to a school representative by an adult. I will assume full responsibility for the supply, appropriate transportation and maintenance of above medication. If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed. I give permission for the exchange of information directly with the healthcare provider regarding my child's medication. **Any medications not picked up by the last day of school by the student's parent/guardian, or other designated adult, will be destroyed.**

_____
Parent/Guardian Home Phone # **Parent/Guardian Work Phone #**

_____
Parent/Guardian Signature **Date**

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing 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
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is student able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

Epilepsy.com

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EPILEPSY FOUNDATION | END EPILEPSY