Westerville City Schools

936 Eastwind Dr., Westerville, OH 43081
Main Office (614) 797-5700 Fax (614) 797-5701

Vision

Our vision is to be the benchmark of educational excellence.

Mission

Our mission is to prepare students to contribute to the competitive and changing world in which we live.

Values

Respect
Inclusiveness
Community
Communication
Collaboration
Innovation
Nurturing
Trust
Accountability

Dear Parent/Guardian,

According to our health records your student has a history of seizures. Please complete and return to school the enclosed forms to ensure your student receives the appropriate care while in school. Medical providers may utilize their own signed forms as long as all necessary action plan and prescribing information is included.

1. **"Questionnaire for Parent of a Student with Seizures"** - Parent/Guardian to complete and sign (2-sided/pages).

2. **"Seizure Action Plan"** – May be substituted with provider Seizure Action Plan. To be completed and signed by both the parent/guardian and medical provider (2-sided/pages). If your student requires medications to be available to them while at school, please have their health care provider write the order for the medication on this form. The form MUST be signed by the medical provider. Medication will be kept in the school health clinic.

3. **"Authorization for the Possession and Use of Seizure Medications"** – To be completed and signed by both the parent/guardian and medical provider if your student is to keep the seizure medication in their possession and/or self-administer the seizure medication.

4. **"Seizure Medication NOT Required at School"** - Please complete and sign if your student has a diagnosis of seizures but no medication is required at school.

Please call or email your student's school nurse with any questions/concerns.

Thank you,

WCSD School Nurses

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

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

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

First aid for any seizure

- D **STAY** calm, keep calm, **begin timing seizure**
- D Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- D **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- D **STAY** until recovered from seizure
- D Swipe magnet for VNS
- D Write down what happens _____
- D Other _____

When to call 911

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

When to call your provider first

- D Change in seizure type, number or pattern
- D Person does not return to usual behavior (i.e., confused for a long period)
- D First time seizure that stops on its' own
- D 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 _____

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EPILEPSY FOUNDATION | END EPILEPSY

EPILEPSY FOUNDATION

Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Contact Information

Student's Name	School Year	Date of Birth	
School	Grade	Classroom	
Parent/Guardian	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	Location	
Significant Medical History or Conditions			

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? _____
2. Seizure type(s)

Seizure Type	Length	Frequency	Description

3. What might trigger a seizure in your child? _____
4. Are there any warnings and/or behavior changes before the seizure occurs? **0** YES ☐ NO
   If YES, please explain: _____
5. When was your child's last seizure? _____
6. Has there been any recent change in your child's seizure patterns? **0** YES ☐ NO
   If YES, please explain: _____
7. How does your child react after a seizure is over? _____
8. How do other illnesses affect your child's seizure control? _____

Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? **D** YES ☐ NO
    If YES, what process would you recommend for returning your child to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? **0** YES ☐ NO
    If YES, please explain:

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 first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Seizure Medication and Treatment Information

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and Time of Day Taken	Possible Side Effects

14. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to Do After Administration

** After 2nd or 3rd seizure, for cluster of seizure, etc.* *** Orally, under tongue, rectally, etc.*

15. What medication(s) will your child need to take during school hours? _____

16. Should any of these medications be administered in a special way? **0** YES ☐ NO

    If YES, please explain: _____

17. Should any particular reaction be watched for? ☐ YES ☐ NO

    If YES, please explain: _____

18. What should be done when your child misses a dose? _____

19. Should the school have backup medication available to give your child for missed dose? **0** YES ☐ NO

20. Do you wish to be called before backup medication is given for a missed dose? **D** YES ☐ NO

21. Does your child have a Vagus Nerve Stimulator? **D** YES **D** NO
    If YES, please describe instructions for appropriate magnet use:

Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

D General health _____ **D**Physical education (gym/sports) _____
DPhysical functioning _____ **D**Recess _____
D Learning _____ **D**Field trips _____
DBehavior _____ **D**Bus transportation _____
DMood/coping _____ **D**Other _____

General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? _____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ☐ YES ☐ NO

Dates _____

Updated _____

Parent/Guardian Signature _____ **Date** _____ _____

DPC77E

Westerville City Schools
Health Services

SEIZURE Medication NOT required at school.

Please sign and return this form to the school nurse

Student:_____

Dear Parent/Guardian,

Our records indicate that your child has a diagnosis of seizures. If no medications are required at school, please sign this form and return it to the school nurse. If medications or other interventions are required, please work with your doctor to fill out the enclosed Seizure Action Plan. Return it to school with any required medication.

Thank You,

WCSD School Nurse

My child, _____does not require any medication at school for his/her seizures. I will inform the school nurse immediately if this plan changes.

_____Date:_____

Parent/Guardian Signature

WESTERVILLE CITY SCHOOLS

AUTHORIZATION FOR THE POSSESSION AND USE OF SEIZURE MEDICATION(S)

Student Name: _____ Date: _____

Address: _____

Authorization is hereby given for the student named above to:

[ ] receive the seizure medication indicated from the designated school personnel.

[ ] keep seizure medication in his/her possession.

[ ] self-administer the seizure medication as permitted by law.

Medication Name: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease: _____

Circumstances under which the drug is to be administered: _____

_____

How the drug is to be administered: _____

_____

Adverse reactions that should be reported to the prescriber: _____

_____

Adverse reactions for an unauthorized user: _____

_____

Procedure to follow in the event that medication does not produce the expected relief from student's seizure:

_____

_____

Other special instructions: _____

_____

Prescriber and parent/guardian names, signature, and emergency phone numbers are required.

Prescriber name: _____ Phone _____

(where Prescriber may be reached in an emergency): _____

Signature: _____ Date: _____

Parent/guardian name: _____ Phone: (Home) _____

(Work) _____

(Other) _____

Signature: _____ Date: _____

Copies must be provided to Principal and to the School Nurse if one is assigned to the student's building.

5/11
2/24/25

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