cCann Technical School
Northern Berkshire Vocational Regional School District

Seizure Safety Plan Acknowledgement

Student Name: ______________________________ **Grade**: __________ **Date of Birth**: ____________

Dear Parent/Guardian,

Please review the statements below and return this signed acknowledgement with your child's Seizure IHP/Safety Plan. New seizure plans and updates may be submitted throughout the school year with medication and/or treatment plan changes. Please have any new plans and orders returned or faxed to the health office. Please note, at McCann, Emergency Medical Services (EMS) are activated by a call to 911. In the case of an emergency, local EMS transports to the nearest medical facility.. You will be notified immediately of this. Safety plans can be downloaded from the "School Nurse" section at mccanntech.org.

Sincerely,

Meghan Kaiser RN, BSN
School Nurse

As the parent/guardian of the above child, I understand/acknowledge that:

- I have read and reviewed the Seizure Safety Plan formulated by my child's physician.
- The plan will be placed on file as part of my child's school health record and the necessary information be shared with my child's teachers and staff.
- My child's seizure history and Safety Plan posted as a medical alert in the electronic student record for staff viewing.
- The school nurse may need to contact the physician completing the Seizure Safety Plan if further information or clarification is needed.
- If emergency medication(s) are ordered by my child's provider, I am responsible for providing the medication to the school health office.
- If emergency medication(s) are ordered by my child's provider but not available at school, 911 will be called and basic seizure first aid will be provided. Emergency medication(s) may not be available if the parent/guardian has not provided the medication to the health office, the student is offsite for field trips, or there are no trained personnel available to administer the medication.
- An action plan should be completed yearly by my child's provider. If a new plan is not received, the most recent plan on file will be followed until a new plan has been submitted.

Parent Signature: ____ **Date**: _________________

Student Signature: ____ **Date**: _________________

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Seizure Safety Plan and Physician Orders

Student Name: ______________________________ **Grade**: __________ **Date of Birth**: ____________

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Please review, complete the plan below, and return along with the Seizure Parent Acknowledgement. This plan should be completed yearly. If a new plan is not received, the most recent plan on file will be followed until a new plan has been submitted to the health office.

Date of plan: ____________

Student's physician/health care provider: ____
Address: ____
Telephone: ______________________________

Parent/Guardian:____
Phone Number: (H) ___________________, (C)___________________, (W) ____________________
Emergency Contact & Phone: ____
(H) _______________, (C)__________________, (W) ________________

Student Specific Seizure Information

Seizure type: ____

Length of time: ____

Frequency:____

Seizure triggers or warning signs:____

Student's response after a seizure:____

Basic First Aid: Care & Comfort

- Call 911 and school nurse 413-663-5383, Ext. 108
- Stay calm and track time of seizure
- Keep child safe; protect head
- Do not restrain; turn student onto side
- Do not put anything in mouth
- Stay with child until fully conscious
- Keep airway open/watch breathing

Please describe basic first aid procedures **specific** to this student:_______________________________
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Emergency Response

A "<u>seizure emergency</u>" for this student is defined as:	**Seizure Emergency Protocol** (Check all that apply and clarify below)
___________________________________	☐ Call 911 for possible transport to local hospital ☐ Contact school nurse 413-663-5383 ☐ Notify parent/guardian or emergency contact ☐ Administer emergency medication(s) as indicated below if available ☐ Notify student's doctor if parent requests ☐ Other___________________________

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

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

Does the student have a **Vagus Nerve Stimulator**? ❒ Yes ❒ No
If yes, describe magnet use:____

**I understand that if emergency medication(s) are ordered by the physician, but are not available, 911 will be called and basic seizure first aid will be provided. Emergency medication(s) may not be available if the parent/guardian has not provided the medication to the school health office, the student is offsite for field trips, or there are no trained personnel available to administer the medication.*

Physician Signature: ______________________________ Date: ____________

Parent Signature: ______________________________ Date:____________

School Nurse Signature: ______________________________ Date:____________