Seizure Action Plan and Medication Authorization: Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician's assistant, and for interscholastic and intramural sports only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a qualified school personnel to administer medication.

School: District:

Name:	DOB:
Parent/Guardian: Home Phone:	Cell Phone:

Type of Seizure Disorder: **Triggers:**

Describe Typical Seizure: **Warning Signs:**

Duration:

Frequency of Seizures in the past year:

Related Medical History:

Home Seizure Medications:

Medication Allergies: ☐ NKDA ☐ Yes:

Vagus Nerve Stimulator? ☐No ☐Yes, Describe Magnet Use:

For All Seizures ⇨
- ✓ Stay calm
- ✓ Speak to student in a reassuring tone
- ✓ Note the time, start a stopwatch if available
- ✓ Notify nurse and keep child/student safe
- ✓ Stay with child/student until fully conscious
- ✓ Do not restrain or put anything in the mouth

For Tonic-Clonic (grand mal) seizure ***follow above and add*** ⇨
- ✓ Turn child/student on side
- ✓ Protect head
- ✓ Keep airway open/watch breathing

HEALTH CARE PROVIDER MEDICATION AUTHORIZATION REQUIRED FOR Emergency Medication IN SCHOOL

1st Medication: & generic name _____ **Dose:** _____ ☐mg ☐squirts ☐other: **Route:** ☐nasal ☐rectal ☐other:

PRN ☐ at onset of seizure or ☐ seizure lasting more than _____ minutes **Side Effects:** ☐ respiratory depression ☐ drowsiness ☐ other:

☐ Other:

2nd Medication: & generic name _____ **Dose:** _____ ☐mg ☐squirts ☐other: **Route:** ☐nasal ☐rectal ☐other:

PRN ☐ at onset of seizure or ☐ seizure lasting more than _____ minutes **Side Effects:** ☐ respiratory depression ☐ drowsiness ☐ other:

☐ Other:

May student return to school activities after recovering from seizure? ☐ Yes ☐ No, dismiss home with parent/guardian

When to Call 911: ☐ Upon administration of Emergency Medication
☐ Repeated seizures without regaining baseline level of consciousness
☐ Does not return to baseline level of consciousness within _____ minutes
☐ Breathing difficulties lasting more than 30 seconds
☐ Seizure occurs while child/student in water

➢ **Prescriber's Signature**: **Date**: **PRESCRIBER'S PRINTED NAME OR STAMP**

Parent: I approve the above ordered medication be administered by school personnel and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. This protocol will be in effect until the end of the current or extended school year. This medication will be destroyed if not picked up within one week following termination of the order or the end of the school year. A new protocol will be needed for the next school year. I have received, reviewed and understand the above information.

➢ **Parent's Signature**: **Date**:

Valid July 1, 2016-June30, 2017

Additional Considerations:

6/13.MC