CFISD FOR ALL
OPPORTUNITY IS HERE.

Cypress-Fairbanks Independent School District

Health Services: Seizure Action Plan

Name: _____ Student ID: _____ DOB: _____/_____/_____

Seizure triggers or warning signs: _____

CFISD staff will **administer medication(s)** as prescribed, **call 911 for emergency medication administration**, and **notify parents** of action plan initiation.

MEDICATION(S)/TREATMENT

Daily medication: _____
(include dose, time, and route)

Emergency medication: **call 911**

[ ] Diastat® _____ mg rectally as needed for:
seizure > _____ minutes OR
_____ seizures in _____ hours

[ ] Other: _____

_____
(include dose, time, and route)

Vagus Nerve Stimulation (VNS): **call 911 at 5 minutes**
[ ] Swipe magnet at seizure onset
[ ] Swipe for report of aura
[ ] Repeat swipe _____times every _____ minutes if seizure persists
[ ] Other: _____

SEIZURE DESCRIPTION

Seizure type: _____

Seizure description: (check all that apply)

[ ] Convulsions [ ] Involuntary rhythmic movements
[ ] Staring [ ] Unconsciousness
[ ] Stiffening [ ] Facial tics

(other information, including average length, frequency, and observations):_____

SEIZURE FIRST AID

- Stay calm and contact the school nurse
- Track seizure start time
- Do not restrain or remove from wheelchair (unless emergency medication must be administered)
- Do not put anything in mouth
- Remain with student
- Protect head

EMERGENCY SEIZURES (call 911)

- Seizure lasting longer than 5 minutes
- Student does not regain consciousness
- Student has a first time seizure
- Student is injured or has diabetes
- Student has difficulty breathing
- Student has a seizure in water

_____ Printed name of HCP
_____ Signature of HCP
(_____) _____-_____ Phone number
_____/_____/20_____ Date

I agree with the recommendations of my child's HCP and authorize CFISD staff to deliver treatment as outlined above. I also give permission for my child's HCP to communicate with appropriate CFISD employees for the current school year.

_____ Printed name, parent/guardian
_____ Signature parent/guardian
(_____) _____-_____ Phone number
_____/_____/20_____ Date

Revised 2/2017

Health Services: Cypress-Fairbanks I.S.D. **Parent/Guardian Consent for Administering Medication** revised 6/16

Student name: _____ **Grade:** _____ **Homeroom:** _____ **Student ID:** _____ **Allergies:** _____

In compliance with CFSID Board policy FFAC (local), all medications administered by CFISD staff must be:

- **delivered to the clinic by a parent/guardian or his/her designee (responsible adult),**
- **supplied in the original container (prescription bottle with prescription label or manufacturer's packaging and will only be administered in accordance with prescriber or manufacturer's guidelines),**
- **prescribed by a medical professional licensed with prescriptive authority in the state of Texas (unless US FDA approved medication available for purchase without a prescription),**
- **US FDA approved for safety and efficacy (school nurse must verify using reputable, peer-reviewed, evidence-based medical literature and may decline administration if she/he finds the dose to exceed current best practice or the medication is otherwise potentially harmful to the recipient),**
- **and retrieved from the clinic by a parent/guardian or his/her designee (responsible adult) by the last calendar day of the current school year or the medication will be destroyed in accordance with District expectations.**

I request Cypress Fairbanks ISD personnel to administer the medication(s) listed below for the 20_____- 20_____ school year:

Parent/guardian phone: (_____)_____-_____ **Parent/guardian email:** _____

Med#1_____	**Med#2**_____	**Med#3**_____
Exp. Date: _____**Route:**_____	**Exp. Date:** _____**Route:**_____	**Exp. Date:** _____**Route:**_____
#1 Dose: _____**Time:** _____	**#2 Dose:** _____ **Time:** _____	**#3 Dose**_____ **Time:** _____
Reason: _____	**Reason:** _____	**Reason:** _____
Date of request: _____/_____/20_____	**Date of request:** _____/_____/20_____	**Date of request:** _____/_____/20_____

I, _____**, parent or guardian of student listed above, authorize the administration of the medication listed above for the current school year and authorize the school nurse or her designee to contact the prescribing healthcare provider for any clarification regarding the requested medication administration.**

Sign/Date: _____	**Sign/Date:** _____	**Sign/Date:** _____

End of year disposition of medication: **O Retrieved by parent/guardian** **O Destroyed by CFISD staff**	**End of year disposition of medication:** **O Retrieved by parent/guardian** **O Destroyed by CFISD staff**	**End of year disposition of medication:** **O Retrieved by parent/guardian** **O Destroyed by CFISD staff**
Sign/Date: _____	**Sign/Date:** _____	**Sign/Date:** _____