Seizure Action Plan

Room #

These forms must be updated by the child's physician every 6 months.

Basic Seizure First Aid	A seizure is generally considered an emergency when	For Tonic-Clonic Seizure
• Stay calm & track time	• Convulsive (tonic-clonic) seizure lasts longer than 5 minutes	
• Keep child safe	• Student has repeat seizures without regaining consciousness	• Protect Head
• Do not restrain	• Student is injured or has diabetes	• Keep airway open
• Do not put anything in mouth	• Students has a first-time seizure	• Turn child on side
• Stay w/ child until fully conscious	• Student has breathing difficulties	
• Record seizure in a log	• Student has a seizure in water	

Student's Name	**Date of Birth**	
Parent/Guardian	**Phone**	**Cell**
Other Emerg. Contact	**Phone**	**Cell**
Treating Physician	**Phone**	

Significant Medical History

Seizure Type	Length	Frequency	Description	Time

Basic First Aid & Comfort: *Please describe basic first aid procedures*

Emergency Response

A seizure emergency for this student is defined as:

	Seizure Emergency Protocol (Check all that apply)
	Contact School Nurse at:
	Call 911 for transport to:
	Notify Parents or Emergency Contact
	Administer emergency medication as indicated below
	Notify doctor
	Other:

Emerg. Med	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions
	☐ Tylenol ☐ or Generic	_____ml ☐Infant (or) ☐Children's Time of Day:	
	☐ Give 1st ☐ Give 2nd ☐ Give Only ☐ Do Not Give at all		
	☐ Motrin ☐ or Generic	_____ml ☐Infant (or) ☐Children's Time of Day:	
	☐ Give 1st ☐ Give 2nd ☐ Give Only ☐ Do Not Give at all		
		Time of Day:	
	☐ Give 1st ☐ Give 2nd ☐ Give Only ☐ Do Not Give at all		

Does student have a Vagus Nerve Stimulator	☐ Yes ☐ No	If YES, describe magnet use:

Special Considerations and Precautions: (regarding school activities, sports, playground, etc.)

Describe:

Parent/Guardian Signature _____ Date _____

Physician Signature _____ Date _____

For Office Use

Parent Form - Must be filled in by parent and resubmitted every six months.

Calvary
Child Development Center

Medical Authorization

CCDC MEDICATION/CARE AUTHORIZATION AND RELEASE

Child's Name: _____ Age: _____

I acknowledge that Calvary Church ("Calvary"), including Calvary Child Development Center ("CCDC"), is not an allergen-free facility, that CCDC cannot guarantee my child will not be exposed notwithstanding awareness of his/her allergies, and he/she may be exposed to an allergen while on-site at CCDC. I also acknowledge that Calvary and CCDC do not employ or provide licensed nurses or physicians on-site during CCDC activities.

I hereby give permission for my child, while present at CCDC, to receive medication in accordance with the Food Allergy Plan for my child or as otherwise indicated below, as prescribed by a licensed physician. I hereby authorize CCDC, including its directors, staff and volunteers, to administer mediation and to provide or arrange for medical care in accordance with the Food Allergy Plan or as indicated below.

For myself and for my child, I release and discharge CCDC, Calvary, its officers, elders, employees, volunteers or other agents from all claims and liability for any loss or injury that may occur in the future as a result of exposure to allergens and any medications or care provided under this authorization and release. I further agree to reimburse, indemnify and hold Calvary and CCDC harmless from any and all costs, claims and liabilities associated with providing or arranging medical care for my child.

Parent/Guardian: _____

Signature_____ Date: _____

Address: _____ Phone_____

Medical Need	Medication	Method of Application	Dosage	Prescribed By

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