My Seizure Response Plan

Name: ______________________ Birth Date: ______________

Address: ______________________ Phone: ______________

1st Emergency Contact /Relation: ______________________ Phone: ______________

2nd Emergency Contact / Relation: ______________________ Phone: ______________

Seizure Information

Seizure Type/Nickname	What Happens	How Long It Lasts	How Often

Triggers

____

____

Daily Seizure Medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other Seizure Treatments

Device Type: ______________ **Model:** ______________ **Serial#** ______________ **Date Implanted** ______________

Dietary Therapy: ______________________ **Date Begun:** ______________

Special Instructions: ______________________

____

Other Therapy: ______________________

____

continued on back

Seizure First Aid

- ☐ Keep calm, provide reassurance, remove bystanders
- ☐ Keep airway clear, turn on side if possible, nothing in mouth
- ☐ Keep safe, remove objects, do not restrain
- ☐ Time, observe, record what happens
- ☐ Stay with person until recovered from seizure
- ☐ Other care needed: ______________________________

Call 911 if...

- ☐ Generalized seizure longer than 5 minutes
- ☐ Two or more seizures without recovering between seizures
- ☐ "As needed" treatments don't work
- ☐ Injury occurs or is suspected, or seizure occurs in water
- ☐ Breathing, heart rate or behavior doesn't return to normal
- ☐ Unexplained fever or pain, hours or few days after a seizure
- ☐ Other care needed: ______________________________

When Seizures Require Additional Help

Type of Emergency (long, clusters or repeated events)	Description	What to Do

"As Needed" Treatments (VNS magnet, medicines)

Name	Amount to Give	When to Give	How to Give

Health Care Contact

Epilepsy Doctor: ______________________________ Phone: ____________________

Nurse/Other Health Care Provider: ______________________________ Phone: ____________________

Preferred Hospital: ______________________________ Phone: ____________________

Primary Care: ______________________________ Phone: ____________________

Pharmacy: ______________________________ Phone: ____________________

Special Instructions: ______________________________

____

My signature ______________________________ Date ____________________

Provider signature ______________________________ Date ____________________

Administration of Medication Form

FORT THOMAS INDEPENDENT SCHOOL DISTRICT

Robert D. Johnson Elementary
441-2444 fax: 572-4948

Ruth Moyer Elementary
441-1180 fax: 441-9440

Samuel Woodfill Elementary
441-0506 fax: 441-2755

Highlands Middle School
441-5222 fax: 441-4210

Highlands High School
781-5900 fax: 442-4212

Dear Parent or Guardian:

If your child requires medication, if possible, please try to schedule it before or after school hours. If the medication is to be given during school hours, we must have this form completed and signed by you and your child's physician. Your doctor may fax this form to the school office. The duration of this form is for one (1) school year only.

SCHOOL YEAR__________________

Name:________________________ Date of Birth____________________

Grade:_______ Allergies:______________________

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Medication:____________________Dosage:_____________________ Directions:____________________

Administration Time: Lunch____or_________Route:_____________Diagnosis:______________________

Possible side effects: ____________________ Duration: Start:______________ Stop:___________________

Medication:____________________Dosage:_____________________ Directions:____________________

Administration Time: Lunch____or_________Route:_____________Diagnosis:______________________

Possible side effects: ____________________ Duration: Start:______________ Stop:___________________

Medication:____________________Dosage:_____________________ Directions:____________________

Administration Time: Lunch____or_________Route:_____________Diagnosis:______________________

Possible side effects: ____________________ Duration: Start:______________ Stop:___________________

****For inhaler, Epipen, FDA approved seizure rescue medication, and/or Glucagon, the student has received training to carry the inhaler or emergency medication and may carry and self-administer this medication. ☐ YES ☐ NO

****For field trips, the student has received training and may carry and self-administer the medication/s listed above. ☐ YES ☐ NO

I give permission for the administration of this medication/s by trained school personnel according to standard school policy and expressly waive any liability on behalf of the school as a result of administration of the above medication/s. School officials may need to contact the ordering physician if additional information is needed. I hereby authorize release of any needed information from the ordering physician regarding this medication. Student may self-administer the above medication/s with school trained personnel supervision while on a field trip. In the case of field trips or school related functions, slight adaptations to the time the medication is administered may also be necessary.

____________________	____________________	____________________
Parent/Guardian Signature	Parent's Phone	Date
____________________	____________________	____________________
Physician's Signature	Physician's Phone	Date
____________________	____________________	____________________
Print Physician's Name	Physician's Address	Fax Number

For student health services/procedures not involving medication only, please refer to 09.22 AP.22.

REVIEW/REVISED:7/11/2016

FORT THOMAS INDEPENDENT SCHOOLS
EMERGENCY MEDICATION ADMINISTRATION
DURING EXTRACURRICULAR ACTIVITIES

Student Name: ______________________
Grade: ____________________________
Date:______________________________

Please list any sports/extracurricular activities that your child will be participating in during the school year:____

I, ______________________________, parent of______________________________________, am aware that my child may require the administration of ____________________ in an emergency situation that occurs before or after normal school hours. I agree to inform the school nurse that my child will participate in extracurricular activities and to inform the coach, leader or responsible adult for these extracurricular activities of my child's condition. **I will supply additional necessary emergency medications or supplies to coaches/leaders for use during these activities.** The school nurse will make available the necessary training to coaches/leader in the administration of these medications. If emergency medication administration is required, 911 will also be called.

If I do not make the medications available, I understand and agree that only 911 will be called in the event of an emergency.

If my child adds additional activities during the school year, I agree to notify the school nurse and coaches/leaders or responsible adult for these extracurricular activities of my child's condition.

______________________________ ____________________
(Signature of parent/guardian) *(Date)*