Ohio Department of Health
Seizure Action Plan (SAP)
For a Student with an Active Seizure Disorder (Epilepsy) Diagnosis
Per ORC 3313.7117 and 3313.713

Department of Health

School Year:

20_____ / 20_____

SAP is effective only for the school year in which it is written.

A. STUDENT INFORMATION (This section completed and signed by Parent/Guardian)

Student:	DOB:	Grade:	School:
Parent/Guardian:	Phone:		Email:
Treating Practitioner:	Phone:		Fax:
School Nurse/School Administrator:	School Phone:		Fax:

As parent/guardian of the above-named student, I give permission for my student's healthcare provider to complete this Seizure Action Plan/Seizure Medication Protocol and share the information with the school nurse/school administrator. I understand the information contained in this plan will be shared with school staff per ORC 3313.7117.

- ✔ I authorize an employee of the school to administer seizure care and prescribed drugs listed in this plan.
- ✔ I understand that additional parent/prescriber signed statements will be necessary if the plan is changed.
- ✔ I also authorize the licensed health care professional to talk with the prescriber or pharmacist to clarify the Seizure Action Plan and/or drug(s) to be given.
- ✔ The Seizure Action Plan must be received by the school nurse, school administrator, or a school employee.
- ✔ I understand that a drug prescribed in this plan shall be provided in the container in which it was dispensed by the prescriber or a licensed pharmacist, to the school nurse or other designated person at the school who is authorized to administer the drug.

Parent/Guardian Name (print):	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:

B. SEIZURE CARE INFORMATION

Seizure Type/Description	Length	Frequency

Seizure triggers or warning signs:

Student specific information:

Does student need to leave the classroom after a seizure? ☐ YES ☐ NO
If YES, describe process for returning student to classroom:

SPECIAL CONSIDERATIONS:

Bus/Transportation:

Field Trips:

Sports:

Emergency situation such as "Lock Down":

Other:

Student Name	DOB:	School Year:

SEIZURE CARE INFORMATION (continued) – Marks all behaviors that apply to student

If you see this:	Do this:
☐ Sudden cry or squeal. ☐ Loss of bowel or bladder control. ☐ Staring. ☐ Rhythmic eye movement. ☐ Lip smacking. ☐ Gurgling or grunting noises. ☐ Falling down. ☐ Rigidity or stiffness. ☐ Thrashing or jerking. ☐ Change in breathing. ☐ Blue color to lips. ☐ Froth from mouth. ☐ Loss of consciousness. ☐ Other (specify): _____	☐ Stay calm and track time. ☐ Report symptoms and duration to parent. ☐ Keep student safe. ☐ Do not restrain. ☐ Protect head. ☐ Keep airway open/watch breathing. ☐ Turn student on side. ☐ Do not put anything in mouth. ☐ Do not give fluids or food during or immediately after seizure. ☐ Stay with student until fully conscious. ☐ Ensure symptoms resolve before student leaves classroom. ☐ Administer prescribed seizure rescue medication. ☐ Swipe VNS magnet. o Describe magnet use and location of implanted device on student: _____ ☐ Other (specify): _____
Expected behavior after a seizure:	**When to CALL 911**
☐ Tiredness. ☐ Weakness. ☐ Sleeping, difficult to arouse. ☐ Somewhat confused. ☐ Regular breathing. ☐ Other (specify):_____ Follow-Up with: ☐ Notify school nurse or school administrator. ☐ Document observations.	☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available. ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available. ☐ Difficulty breathing after seizure. ☐ Serious injury occurs or suspected, seizure is in water. ☐ Other (specify): _____

SEIZURE MEDICATION PROTOCOL DURING SCHOOL HOURS (Completed by Treating Practitioner)

Name of Medication/Dose (how much)	Route (how to give)	When to give (seizure cluster, # or length)

Licensed Healthcare Professional Authorized to Prescribe

Treating Practitioner Name (print):	Signature:	**Authorization Dates:**
Phone Number:	Practice Address:	**Start Date:** _____ **Stop Date:** _____

Student Name	DOB:	School Year:

C. FOR SCHOOL USE ONLY (Completed by School Nurse or School Administrator).

EMERGENCY SEIZURE RESCUE MEDICATION and SEIZURE DISORDER CARE

Designated person(s) trained to give seizure disorder care, seizure medication, and/or use VNS magnet:

School Employee(s) (specify name)	Dates of Training (Required every 2 years)

Location of seizure rescue medication (must be locked but accessible) and/or VNS magnet:

SCHOOL NURSE or SCHOOL ADMINISTRATOR

Distribution of and training on the Seizure Action Plan (this form) to the school staff who (1) regularly interacts with the student; (2) has legitimate educational interest in the student or is responsible for direct supervision of the student; (3) is responsible for transportation of the student to and from school.

Specify Names	Date SAP received/trained
☐ Front office/administrative staff:	
☐ Teacher(s)/classroom staff:	
☐ Transportation:	
☐ Other(s):	

Seizure Action Plan (this form) is the responsibility of and maintained in the office of:

☐ School Nurse and/or ☐ School Administrator

School Nurse Signature:	Date:
School Administrator Signature:	Date:

ADDITIONAL INFORMATION FOR SCHOOL USE