St. Mary's Catholic Church & School

Faith - Scholarship - Leadership - Service

405 Hollybrook Drive, Longview, TX 75605 • www.stmaryslgv.com

**Seizure Action Plan**

This student is being treated for a seizure disorder. The information below will assist the school personnel if a seizure would occur during the school day.

Student's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone number(s): _____

Physician: _____ Phone number: _____

Significant medical history: _____

**Seizure information**

Type of seizure: _____ Length: _____ Frequency: _____

Last seizure: _____ Student's reaction to seizure: _____

Seizure triggers for warning signs: _____

_____

**Basic First Aid**

Stay calm, keep student safe d, do not restrain or put anything in the student's mouth, stay with student until fully conscious, then record on seizure log, keep airway open/watch breathing, and turn child on side

Describe needs for this student: _____

_____

Does this student need to leave the classroom after a seizure? Yes _____ No _____

If yes, describe process for returning student to the classroom: _____

Emergency Responses

A seizure is generally considered an emergency when: A convulsive seizure last longer than 5 minutes, student has repeated seizures without regaining consciousness, student has a first-time seizure, student is injured or has diabetes, student has trouble breathing, student has a seizure in water

A seizure for this student is defined as: _____

Seizure Emergency Protocol: check all that apply:

_____ Contact School Nurse

_____ Call 911 for transport to: _____

_____ Notify parent or emergency contact

_____ Notify Physician

_____ Administer emergency medications as indicated below

_____ Does student have a Vagus Nerve Stimulator (VNS) Yes_____No____

If yes, describe magnet use: _____

**Treatment Protocol during school hours**: (include daily and emergency medications)

_____

Emergency/Rescue Medications: _____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

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## MEDICATION PERMIT FORM

Only necessary medication (such as for epileptics, asthmatics, diabetics, ADD/ADHD may be given at school. All medication should be given outside of school hours if possible. Three times a day medication should be given before school, after school, and at bedtime for optimal coverage. If necessary, medication can be given at school only under the following conditions:

1. **If medication is needed in order for the student to remain in school, this form must be completed by the parent/legal guardian, and returned with the medication to the school office.**

2. All medication, **including cough drops,** must be in the **original container** with instructions for dosage. All prescription medicines must be in the original pharmacy container with a current pharmacy label showing the student's name as the patient, and the name of the doctor or dentist who prescribed the medication. The pharmacy can supply two labeled bottles so one can be used for school. **Medications sent in unlabeled containers will not be accepted or given to the student.**

3. The parent is responsible for delivering and picking up medications for school office use. Any unused meds left at the end of the dates on this form will be destroyed.

4. Antibiotics will not be given at school by school personnel. If the parent feels the antibiotic must be given during the day, the parent may come to the school and administer it.

5. All medications must be kept in a locked cabinet/drawer in the school office. **Students should never have medications in their possession at school or school activities.**

6. **Only parents/legal guardians may transport medications from home to the school office and return unused medications home.**

7. Only office personnel and/or the parent may perform nebulizer treatments in school.

TO THE OFFICE PERSONNEL OF ST. MARY'S CATHOLIC SCHOOL:

NAME OF STUDENT:_____GRADE:_____

NAME OF MEDICATION:_____

DOSAGE/DIRECTIONS FOR ADMINISTERING: _____

BEGINNING DATE:_____ENDING DATE:_____

I hereby request that the medication specified above be given to the above-named student and that the medication may be given by someone other than a medically trained person.
I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Diocese of Tyler, its servants, agents, and employees, including but not limited to the parish, the school, the principal and individuals giving the medication of and from any and all claims, demands, or causes of action arising out of or in any way connected with giving the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parents/legal guardians of the student, hereby release and waive any and all claims, demands, or causes of action against the Diocese of Tyler, its agents, servants, or employees, including but not limited to the parish, the school, the principal and the individual giving or failing to give the medication.

SIGNATURE OF PARENT/LEGAL GUARDIAN_____DATE:_____

NAME OF PHYSICIAN/DENTIST:_____PHONE :_____

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