Arizona Autism Charter School
Request for Medical Documentation – Seizures

Dear Parent/Guardian,

Attached are forms for your student for the upcoming school year. New forms are required each year. The forms attached are:

1. Seizure Disorder History Form to be filled out by parent
2. Seizure Care Plan to be filled out by licensed health care provider
3. Consent for Medication Administration Form, to be filled out by the parent and the licensed health care provider.

Please complete the Consent for Medication Administration form if your student requires over the counter or prescription medication during the school day.
If you would like to request a meeting with the nurse regarding your child's health care needs, please let me know and we can arrange a meeting.

Feel free to contact the school health office with any questions.

Thank you,

Jessica Mangieri, RN, BSN
AZACS School Nurse
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Arizona Autism Charter School

SEIZURE DISORDER HISTORY

Instructions: Complete and return form to the school health office

Student Name: ____
ID: _________________________________
DOB: _______________________________
Date: _______________________________

Name of adult completing the form: ____________________________________

Circle one: Mother Father Grandparent Guardian/Primary Caregiver

1. What type of seizures does your student have?
   ____
2. How often do seizures occur? How long do they last?
   ____
   ____
3. When was your child's last seizure?
   ____
4. Has your child ever stopped breathing during a seizure? No Yes
   If so, how was that handled?
   ____
5. Please list any known seizure triggers:
   ____
6. Does your student require the use of any protective equipment (i.e. helmet)? No Yes
   If yes, please explain:
   ____
7. Please list any **daily** seizure medications
   ____
   ____
8. Please list any RESCUE medications with dosages:
   ____

*If the student requires RESCUE or DAILY medication to be carried at school, please fill out attached MEDICATION ADMINISTRATION FORM****

Parent/Guardian Signature: ______________________________________ Date: ________________

SEIZURE ACTION PLAN (SAP)

Name: _______________ Birth Date: _______________

Address: _______________ Phone: _______________

Emergency Contact/Relationship _______________ Phone: _______________

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at _______________
- ☐ Call 911 for transport to _______________
- ☐ Other _______________

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _______________
- ☐ Other _______________

When to call 911

- ☐ 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 in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _______________

Name of Med/Rx _______________ How much to give (dose) _______________

How to give _______________

If seizure (cluster, # or length) _______________

Name of Med/Rx _______________ How much to give (dose) _______________

How to give _______________

If seizure (cluster, # or length) _______________

Name of Med/Rx _______________ How much to give (dose) _______________

How to give _______________

Care after seizure

What type of help is needed? (describe) ____________________

When is person able to resume usual activity? ____________________

Special instructions

First Responders: ____________________

____

Emergency Department: ____________________

____

Daily seizure medicine

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

Other information

Triggers: ____________________

Important Medical History ____________________

Allergies ____________________

Epilepsy Surgery (type, date, side effects) ____________________

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted ____________________

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) ____________________

Special Instructions: ____________________

____

Health care contacts

Epilepsy Provider: ____________________ Phone: ____________________

Primary Care: ____________________ Phone: ____________________

Preferred Hospital: ____________________ Phone: ____________________

Pharmacy: ____________________ Phone: ____________________

My signature ____________________ Date ____________________

Provider signature ____________________ Date ____________________

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Medication Administration in School

Child's Name:		Date of Birth:
Name of Medication:	**Dosage:**	**Time:**

I request that authorized school staff give my child the medication noted above, according to the Heath Care Provider's signed instruction on the lower part of this form.

The School agrees to administer medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to furnish the medication. The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription Medications: must come in a container labeled with child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the Counter Medication: must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the school staff delegated to administer medication.

SIGN HERE

Parent/ Legal Guardian Name ______________ **Signature** ______________ **Date** ______________

Work Phone ______________ **Cell Phone** ______________

Health Care Provider Authorization to Administer Medication in School

Child's Name:	DOB:
Medication:	
Dosage:	**Route:**
To be given at the following time(s):	
Special Instructions:	
Purpose of medication:	
Side effects that need to be reported:	
Start Date:	**End Date:**

SIGN HERE

Signature of Health Care Provider with Prescriptive Authority ______________ **License Number** ______________

Phone Number______________ ***Date***______________

Please ask the pharmacist for a separate medicine bottle to keep at school. Thank you!