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
602-882-5544
jmangieri@autismcharter.org
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

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>How Long It Lasts</th>
<th>How Often</th>
<th>What Happens</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

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 __________________________

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

<table>
<thead>
<tr>
<th>Medicine Name</th>
<th>Total Daily Amount</th>
<th>Amount of Tab/Liquid</th>
<th>How Taken (time of each dose and how much)</th>
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</thead>
<tbody>
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</table>

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 _________________________
Medication Administration in School

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Medication:</td>
<td>Dosage:</td>
</tr>
</tbody>
</table>

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.

Parent/ Legal Guardian Name

Signature

Date

Work Phone

Cell Phone

Health Care Provider Authorization to Administer Medication in School

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication:</td>
<td></td>
</tr>
<tr>
<td>Dosage:</td>
<td>Route:</td>
</tr>
<tr>
<td>To be given at the following time(s):</td>
<td></td>
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<tr>
<td>Special Instructions:</td>
<td></td>
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<tr>
<td>Purpose of medication:</td>
<td></td>
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<tr>
<td>Side effects that need to be reported:</td>
<td></td>
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<tr>
<td>Start Date:</td>
<td>End Date:</td>
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</tbody>
</table>

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!**