BERKELEY TOWNSHIP SCHOOL DISTRICT

Health Services

Medical Packet for Students with Seizure Disorders

Dear Parent/Guardian:

"Paul's Law" authorizes parents or guardians to request the use of an individualized health care plan for students with epilepsy or seizure disorders.

Seizure Action Plans and Individualized Health Care & Emergency Health Care Plans

The parent or guardian of a student with epilepsy or a seizure disorder who seeks epilepsy or seizure disorder care while at school shall **annually** submit to the school nurse the student's seizure action plan. The school nurse shall develop an individualized health care plan and an individualized emergency health care plan for the student, as long as the student's parent or guardian annually provides the board of education with written authorization for the provision of epilepsy or seizure disorder care.

Information Sharing

The school nurse shall obtain a release from the parent or guardian of a student with epilepsy or a seizure disorder to authorize the sharing of medical information between the student's physician or advanced practice nurse and other health care providers. The release shall also authorize the school nurse to share medical information with other staff members of the school district as necessary. In the event that a school bus driver transports a student with epilepsy or a seizure disorder, the school district shall provide the driver with a notice of the student's condition, information on how to provide care for epilepsy or the seizure disorder, emergency contact information, epilepsy and seizure disorder first aid training, and parent contact information.

Required Documents:

1. Seizure Action Plan (SAP)
    a. Completed and signed by Physician/APN
    b. Signed by Parent/Guardian
2. Seizure IHP & ECP
    a. Parent/Guardian to complete Student Information section on Page 1 and Signature section on Page 2
    b. Include Full Color Photo
    c. Completed by School Nurse upon receipt

Please work with your child's medical provider to complete the enclosed documents and contact your child's school nurse prior to your child starting school. Medication must be supplied to the school nurse in a properly labeled container, with the child's name, dosage, etc., on the pharmacist's label and must be brought to school by a parent or guardian.

Sincerely,

School Nurse

Bayville School
356 Atlantic City Boulevard
Bayville NJ 08721
(732) 269-1300

Clara B. Worth School
57 Central Parkway
Bayville NJ 08721
(732) 269-1700

H & M Potter School
60 Veeder Lane
Bayville NJ 08721
(732) 269-5700

Berkeley Township Elementary School
10 Emory Avenue
Bayville NJ 08721
(732) 269-2909

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 _____

Epilepsy.com

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EPILEPSY FOUNDATION | END EPILEPSY

SEIZURE Individualized Healthcare Plan (IHP) Emergency Care Plan (ECP)	School Year:	Picture
	SAP ☐Yes ☐No	

STUDENT INFORMATION			
Student:	**DOB:**	**Grade:**	**School:**
Parent:	**Phone:**		**Email:**
Physician:	**Phone:**		**Fax:**
School Nurse:	**School Phone:**		**Fax:**
History:			

SEIZURE INFORMATION		
Seizure Type/Description	**Length**	**Frequency**
Seizure triggers or warning signs:		
Student's reaction to seizure:		

SPECIAL CONSIDERATIONS
Special considerations and precautions (regarding school activities, field trips, sports, etc):

EMERGENCY SEIZURE RESCUE MEDICATION (See SAP)
Person to give seizure rescue medication: ☐ School Nurse ☐ Parent ☐ EMS
Location of seizure rescue medication (must be locked):

VAGUS NERVE STIMULATOR (VNS) (See SAP)
This student has a Vagus Nerve Stimulator: ☐ Yes ☐ No Location of magnet:
Person(s) trained on magnet use:
Describe magnet use:

CONTINUED ON NEXT PAGE →

Student Name:	**DOB:**

SEIZURE ACTION PLAN – Mark all behaviors that apply to student

If you see this:	***Do this:***
□ Sudden cry or squeal □ Falling down □ Rigidity/Stiffness □ Thrashing/Jerking □ Loss of bowel/bladder control □ Shallow breathing □ Stops breathing □ Blue color to lips □ Froth from mouth □ Gurgling or grunting noises □ Loss of consciousness □ Staring □ Lip smacking □ Eye movement □ Other: _____	**BASIC SEIZURE FIRST AID** ▪ Stay calm & track time ▪ Keep child safe ▪ Do not restrain ▪ Do not put anything in mouth ▪ Stay with child until fully conscious ▪ Protect head ▪ Keep airway open/watch breathing ▪ Turn child on side ▪ Do not give fluids or food during or immediately after seizure
EMERGENCY SEIZURE PROTOCOL	***Expected Behavior after Seizure***
□ Call 911 at ____ minutes for transport to:_____ □ Call parent or emergency contact □ Administer emergency medications as indicated on SAP □ Other (specify): **A seizure is generally considered an emergency when:** ▪ Convulsive (tonic-clonic) seizure lasts longer than 5 minutes ▪ Student has repeated seizures with or without regaining consciousness ▪ Student is injured, pregnant or has diabetes ▪ Student has a first-time seizure ▪ Student has breathing difficulties ▪ Student has a seizure in water	▪ Tiredness ▪ Weakness ▪ Sleeping, difficult to arouse ▪ Somewhat confused ▪ Regular breathing ▪ Other:

SIGNATURES

As parent/guardian of the above named student, I give permission for my child's healthcare provider to share information with the school nurse for the completion of this plan of care. I understand the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student's health status, care or medication order. If medication is ordered, I authorize school staff to administer medication described below to my child. If prescription is changed, a new SAP must be completed before the school staff can administer the medication. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.

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

SCHOOL NURSE

Seizure Emergency Care Plan (this form) distributed to 'need to know' staff:
□ Front office/admin □Teacher(s) □Transportation □ Other (specify):

School Nurse Signature:	Date: