Oak Park School District
Seizure Management Plan

Child's picture

Student's Name: _____ School Year: _____

School Attending: _____

DOB: _____ Grade: _____ Teacher: _____

Reviewed by: _____ on _____
(Healthcare Provider Signature) Date

Acknowledged by: _____ Cell #1: _____
(Parent/Guardian Signature) Cell #2: _____

Acknowledged by: _____ on _____
(District Nurse Signature) Date

Signs/Symptoms of Seizure Activity may include all or some of the following:

1. Blank staring
2. Rapid eye blinking
3. Drooling
4. Clenching hands
5. Waving arms
6. Shaking/twitching of extremities
7. Nonsense speech
8. Drooping of the mouth or cheek
9. Repetitive movement of a body part
10. Grinding teeth
11. Uncontrolled shaking of 1 or more body parts
12. Student may fall down or lose consciousness

Triggers/Symptoms (Specific to Student)

1. How often does seizure activity occur? _____
_____
2. Has hospitalization been needed in the past year for seizure activity? ☐ Yes ☐ No
3. Seizures are currently being treated by Dr. _____
4. What does the child's seizure look like and how long does it last? _____
_____
5. List conditions that usually cause the seizure (e.g. noise, blinking lights) _____
_____
6. Does the student use any special activity adaptations or protective equipment (e.g., helmet) at school? ☐ Yes ☐ No (Describe) _____
7. Is the use of a magnet used to stop the seizure? ☐ Yes ☐ No
   If Yes, where is it located?_____

Are medications needed to control the seizures? ☐ No ☐ Yes

	Medication	Dose/Route
#1		
#2		

Bus Information to be completed by Parent/Guardian

Medication is to be available on the bus: Please circle → YES NO
If Medication ***IS*** to be available on the bus, I _____,
parent/guardian of _____ understand that I must provide an extra medication to be carried to and from school in the front pocket of the backpack. Transportation will be notified.

Acknowledged by District Nurse: _____ **Date** _____

PARENT/GUARDIAN:

I request and give permission for (name of student)_____,
to receive the above medication(s)/treatment at school according to standard school district policy and for the physician or physician's staff and school district staff to share information needed to assist my child with medication needs. Schools require parent/guardian to bring medication in its original container (no exceptions will be made if not in original container). All medication must be labeled with the student's name and must be current.

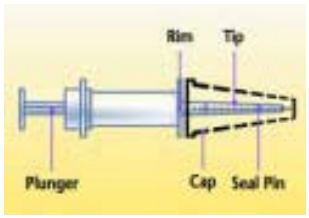
_____ _____
Parent/Guardian Signature **Date**

Students with health/medical issues may be eligible for protection under Section 504, a federal disability law. Parents who wish to initiate a request for a 504 evaluation should contact the office of Specialized Student Services at 248-336-7673.

If a seizure last longer than
3-5 MINUTES

Give Diastat
(If ordered by physician)

1. **Put person on their side where they can't fall**



2. **Get medicine**

3. **Push up w/thumb & pull to remove protective cover from syringe**

4. **Lubricate rectal tip w/lubricating jelly**

5. **Turn person on side facing you**

6. **Bend upper leg forward to expose rectum**

7. **Separate buttocks to expose rectum**

8. **Gently insert syringe tip into rectum**

9. **Slowly count to 3 while gently pushing plunger in until it stops**

10. **Slowly count to 3 before removing from rectum**

11. **Slowly count to 3 holding buttocks to prevent leakage**

12. **Keep person on side facing you, note time given and continue to observe**

Building Authorization:_____Date:_____

Total number of Diastat kits supplied to district: _____

☐ **School Office** ☐ **Classroom** ☐ **Other: _____**

revised 5/20 cd