

Student Name: _____



Oxford Community Schools **SEIZURE Medical Action Plan (MAP)**

Student's Name _____
Date of birth _____ **School** _____
Age _____ **Grade** _____ **School Year** _____

Child's
picture

Page one of this MAP is to be completed, signed and dated by a parent/guardian.
Page two of this MAP is to be completed, signed and dated by the treating physician/licensed prescriber.
Without signatures this MAP is not valid. The parent/guardian is responsible for supplying all medication & any other supplies required.

CONTACT INFORMATION

	<u>Call First</u>	<u>Try Second</u>
Parent/ Guardian:	Name: _____ Relationship: _____	Name: _____ Relationship: _____
Phone:	Home: _____ Cell: _____ Work: _____	Home: _____ Cell: _____ Work: _____
Call Third (If a parent/guardian cannot be reached)	Name: _____ Address: _____	Relationship: _____ Phone: _____

SEIZURE HISTORY

Seizure Type (please check all that apply)

Generalized: **Tonic Clonic** (grand mal) **Atonic** (drop attacks) **Myoclonic** **Absence** (petit mal)

Partial: **Simple** **Complex** (psychomotor/temporal lobe)

Other or Description of seizure _____

How long does a typical seizure last _____ **How often do seizures occur** _____

Warning signs (aura) or triggers if any, please explain _____

Age when seizures were diagnosed _____ **Date of last exam for this condition** _____

Student on ketogenic diet YES NO **Past history of surgery for seizures** YES NO

Student's reaction to seizure _____

Does student need to leave the classroom after a seizure? YES NO

If yes, describe process for returning to classroom _____

Notify parent immediately for all seizure activity YES NO

Other instructions _____

Any special considerations or safety precautions: _____

I have received the attached information regarding Section 504 eligibility YES NO
I wish to be contacted regarding a 504 evaluation YES NO

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having seizures to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) I give permission for trained staff to administer any medication ordered for seizure activity and to contact the ordering physician/licensed prescriber for clarification of this plan if needed.

Date _____ Parent/Guardian _____
Signature

Bus # _____
Driver: _____
Route # _____
Transportation Office Use ONLY if needed
Medical File

Action if student has a seizure

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully awake
- Record seizure in a log

In addition for tonic-clonic (grand mal) seizure

- Keep airway open/watch breathing
- Protect head
- Turn child on side, if able to safely
- Follow medical orders (last box below)
- Follow directions of parent (page one of MAP)

General Signs of a Seizure EMERGENCY

- Convulsion (tonic-clonic/grand mal) **longer than 5 minutes** or per 911 instructions below in Order
- Student has repeated seizures without regaining consciousness
- Student is injured, has diabetes, or is pregnant
- Student has breathing difficulties, or normal breathing does not resume
- Student has a seizure in water
- Parents request emergency evaluation



Action

- Stay with the student until help arrives
- Call parent/guardian
- CPR if needed

CALL 911

Physician/Licensed Prescriber Order & Agreement with Protocol (as outlined in this 2 page plan)

Administer Diastat® rectal gel for seizure lasting longer than _____ minutes. **Dose** _____

Other instructions for Diastat® _____

No Diastat® ordered

Does student have a Vagal Nerve Stimulator YES NO (if YES, please describe magnet use)

Call 911 if: (please check and complete all that apply)

† Seizure does not stop by itself within _____ minutes

† Anytime Diastat is given

† Only if seizure does not stop within _____ minutes after giving Diastat

† Other directions or medications:

Physician/Licensed Prescriber's Name _____

Phone number _____ **FAX number** _____

Signature _____ **Date** _____



Notice of Section 504 Procedural Safeguards

1. Have the District advise you of your rights under federal law;
2. Receive notice with respect to Section 504 identification, evaluation, educational program and/or placement of your child;
3. Have an evaluation, educational and placement decisions made for your child based upon information from a variety of sources and by a team of persons who are knowledgeable about the student, the meaning of evaluation data, and placement options;
4. Have your child receive a free appropriate public education, which is the provision of regular or special education and related aids and services that are designed to meet individual educational needs of your child as adequately as the needs of students without disabilities are met, if your child is Section 504 eligible;. If your child is Section 504 eligible, your child also has the right to have the District make reasonable accommodations to allow your child to an equal opportunity to participate in school and school-related activities;
5. Have your child be educated with non-disabled students to the maximum extent appropriate, if the child is Section 504 eligible;
6. Have your child take part in and receive benefits from the District's education programs without discrimination on the basis of disability;
7. Have your child educated in facilities and receive services comparable to those provided to non-disabled students;
8. Examine all relevant records of your child, including those relating to decisions about your child's Section 504 identification, evaluation, educational program, and placement; and obtain copies of those records at a reasonable cost, unless the fee would effectively deny you access to the records;
9. Receive a response from the District to reasonable requests for explanations and interpretations of your child's records;
10. Receive information in your native language and primary mode of communication;
11. Have a periodic re-evaluation of your child, including an evaluation before any significant change of placement;
12. Have your child given an equal opportunity to participate in nonacademic and extracurricular activities offered by the District;
13. Request and participate in an impartial due process hearing regarding the identification, evaluation, or placement of your child, including a right to be represented by counsel in that process and to appeal an adverse decision;
14. File a complaint in accordance with the District's grievance procedures or with the U.S. Department of Education, Office for Civil Rights.