Brazos Independent School District
Health Services Department
Bailey Demny, BSN, RN, District Nurse, BES Clinic Phone: (979)478-6032
Linda Toman, Clinical Assistant, BMS: (979)478-6045 BHS: (979)478-6005

Dear Parent,

Our records indicate that your child _____ has a diagnosis of seizure disorder that may require treatment at school. Attached to this letter are the forms, listed below, that will give us the necessary information and authorization to treat your child in an emergency.

- **Medication Request Permission form** - One should be used for each medication sent to school.
- **Seizure Action Plan** - To be completed by doctor and parent annually and updated with any changes.

Please provide any needed medication with a medication consent form. If we do not have these forms and supplies on hand and your child has a seizure while at school, we will call 911 to assure your child's safety, and/or notify parent or guardian.

It is important for your child's safety that we have the proper authorizations and supplies on hand in order to respond in an emergency. These items need to be provided to the nurse's office as soon as possible. We appreciate your help in our effort to provide the best care for your child.

Thank you,

Bailey Demny, BSN, RN

Bailey Demny, BSN, RN
Brazos ISD District Nurse

Seizure Management and Treatment Plan Form

Texas Education Agency

This form is designed to help create a plan for managing student seizures. It consists of questions about seizure history, medications, precautions, and other considerations. This form should be completed jointly by the student's parents and treating physician and provided to the campus nurse or other appropriately identified personnel.

Student Name: _____ **Date of Birth:** _____ **Date:** _____

Parent/Guardian: _____ **Phone:** _____ **Email:** _____

Emergency Contact/ Relationship: _____ **Phone:** _____ **Email:** _____

Seizure Information

Seizure Type	Length (How long it lasts)	Frequency (How often)	What Happens During a Seizure

Known Seizure Triggers or Warning Signs

☐ Missed Medicine ☐ Emotional Stress ☐ Lack of Sleep

☐ Physical Stress ☐ Flashing Lights ☐ Missing Meals

☐ Illness with High Fever ☐ Alcohol/Drugs ☐ Menstrual Cycle

☐ Response to specific food or excess caffeine. Specify:

_____

☐ Other: _____

VNS/Devices

Devices: VNS ☐ RNS ☐ DBS ☐

Date Implanted: _____

Magnet Use/Instructions:

_____

Basic first aid to be provided during a seizure

- **STAY** calm, keep calm, begin timing the seizure
- Keep the student **SAFE**: remove harmful objects, don't restrain, and protect their head
- Turn the student on **SIDE** if not awake, keep airway clear, don't put objects in mouth
- **STAY** until the student recovers
- **SWIPE** magnet for VNS
- Write down what happened during the seizure
- Other:

When to call 911 – A seizure emergency for the student

- Seizure with a loss of consciousness longer than five minutes and not responding to rescue medicine if available
- Repeated seizures lasting longer than 10 minutes, with no recovery between them and the student is not responding to available rescue medicine
- Difficulty breathing after seizure
- Serious injury occurs or is suspected; seizure in water

When to call student's doctor first

- A change in seizure type, number, or pattern
- Student does not return to usual behavior (i.e., confused for a long period)
- A first time seizure that stops on its own
- Other medical problems or a pregnancy needs to be checked

Student name: _____ Date of birth: _____

Seizure Emergency Protocol for District Personnel to Follow

- Administer emergency medications
- Contact school nurse: _____
- Call 911; transport to _____
- Notify parent or emergency contact and doctor
- Other: _____

When and What to Do When Rescue Therapy is Needed

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: _____

Student's Response and Care After a Seizure

What type of help is needed? _____
When is the student able to resume usual activity? _____
Does the student need to leave the classroom? Yes ☐ No ☐
If yes, when can the student return to the classroom? _____
Is the student able to manage and understand their seizures? Yes ☐ No ☐

Special Instructions

First Responders: _____
Emergency Department: _____

Daily Seizure Medication

Medication Name	Dosage	Time to be Given	Common Side Effects	Special Instructions

Other Information

Important medical history: _____
Allergies: _____
Epilepsy surgery (type, date, side effects): _____
Diet therapy: Ketogenic ☐ Low-Glycemic ☐ Modified Atkins ☐ Other: _____
Special considerations, instructions, or precautions (i.e., school trips, activities, sports, etc.): _____

Health Care Contacts

Epilepsy Provider: _____ Phone: _____
Primary Care: _____ Phone: _____
Preferred Hospital: _____ Phone: _____
Pharmacy: _____ Phone: _____
Parent/Guardian Signature: _____ Date: _____
Epilepsy Provider Signature: _____ Date: _____