DePaul Catholic
High School

1512 Alps Road, Wayne, NJ 07470-3695
973.694.3702 | Fax: 973.633.5381 | http://www.depaulcatholic.org

It has been noted in your child's file, that your child has had a health history of seizures. I've enclosed a copy of our seizure action plan, the necessary paperwork to be completed by both physician and parent. This form will be used for the 20___-20___ school year. Please fill out all the necessary information and return it to the school's health office prior to your child's first day of school.

This paperwork is required so that your child can be cared for properly.

If this does not pertain to your child, please fill in only the second page and return it to the health office and no further paperwork needs to be returned.

If you have any concerns or questions please feel free to contact me at school 973-694-3702 x 270, Fax - 973-694-6232. Thank you for your anticipated cooperation with this matter.

Sincerely,
School Nurse

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Dear Parent or Guardian,

If your child does not have a health history of seizures, please check off the appropriate box below and return only this page back to the school nurse.

Please call our office if you have any questions or concerns.

Regards,
School Nurse

Student's Name: _____ *Grade:* _____

☐ *My child has never had a history of seizures or any seizure activity (including atonic, clonic, tonic, myoclonic, partial-focal or generalized seizures, epilepsy). Please make a note of this for your records.*

Parent Name (Please print): _____*Date:*_____

Parent Signature: _____

Other Comments: _____

2/17/17

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Seizure Action Plan For School

Student Name _____ DOB _____ Date _____

Type of seizure: _____

What does the seizure look like and how long does it usually last: _____

_____

Possible triggers that should be avoided: _____

_____

Does your child need any special activity adaptations/protective equipment (e.g., helmet-pads) at school?

No ____ Yes ____ (explain) _____

_____

Is your child allowed to participate in physical education and other activities?

No ____ Yes ____ (explain) _____

_____

Are Medications needed to control the seizures? No ____ Yes ____ (please list below)

Medications	Dosage	Taken at School (circle one)	How often and for what signs/symptoms
1._____	_____	Yes or No	_____
2._____	_____	Yes or No	_____
3._____	_____	Yes or No	_____
4._____	_____	Yes or No	_____

Possible side effects that must be reported to parent or physician: _____

_____

<u>If Generalized Seizure Occurs</u>:

1. If falling, assist student to the floor, turn on side
2. Loosen clothing at neck and waist, protect head from injury
3. Clear away furniture and other objects from area
4. Have another adult direct other students away from the area
5. Time the seizure and allow seizure to run its course
6. DO NOT restrain or insert anything into student's mouth. DO NOT try to stop purposeless behavior
7. During a general or grand mal seizure, expect to see pale or bluish discoloration of skin/lips
8. Expect to hear noisy breathing

If Smaller Seizure Occurs: (e.g. lip smacking, behavior outburst, staring, twitching of mouth/hands):

1. Assist students to comfortable, sitting position
2. Time seizure
3. Stay with student, speak gently/quietly
4. If he/she is able to, assist student to return to activities/class

If Student Exhibits the following: CALL 911 and START CPR (for absent breathing or pulse)

1. Absence of breathing or pulse
2. Seizure of 10 minutes or greater duration
3. Two or more consecutive (without a period of consciousness between) seizures which total 10 minutes or greater
4. Continued unusually pale or bluish skin/lips, or noisy breathing after the seizure has stopped

When Seizure Completed:

1. Re-orient and assure student:
    a. Assist a change into clean clothes if needed
    b. Allow student to sleep if needed
    c. Allow student to eat, once fully awake/alert
2. A student recovering from a generalized seizure may exhibit abnormal behavior such as incoherent/slurred speech, extreme restlessness/confusion (lasting minutes to hours)
3. Contact/Inform parent immediately of seizure, what occurred and if 911 emergency call was activated

If you want additional care to be given, please describe these actions below:

If symptoms are:_____

_____

Give (medication/dose/route): _____

_____

Possible side effects:

_____

Physician Signature _____ Date _____

Physician Name (Print) _____ Phone _____

□ I want this plan implemented for my child _____, in school. I hereby give my permission for exchange of confidential information contained in the records of my child between the nurse and physician and my signature is an informed consent to share this medical information school staff as a need to know for academic success and emergency plan as determined by the nurse.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name (Print) _____ Date _____

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PERMISSION TO SHARE INFORMATION
20___-20___

As you are aware, everyday each of our students has contact with a variety of staff members: teachers, bus drivers, therapists, assistants, cafeteria workers, and student interns. While your child is in the care of these people, it is important that they are aware of any information that would require special considerations for his or her health and safety.

To comply with privacy laws, I am requesting your permission to share personal information about your child. This would consist of only that information deemed necessary to protect the well-being of your child. Examples of information that could be shared about your child may include: known allergies, special diets or food restriction, and a history of seizures. This may be done in the form of a printed list or verbal contact with those people who will be working closely with your child. If you have specific questions regarding your child, please call me at school. As always, please feel comfortable knowing that any information you do not want shared with anyone will be kept confidential. Thank you.

PLEASE COMPLETE, SIGN BELOW AND RETURN THIS FORM TO YOUR CHILD'S SCHOOL

Child's Name: _____

_____ **Yes**, I give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.

_____ **No**, I do not give permission for personal information about my child to be shared with other staff members if it will protect his/her health and safety.

_____ _____

Parent/Guardian Signature Date

DE PAUL CATHOLIC HIGH SCHOOL 20___ - 20___
EMERGENCY INFORMATION CARD

Please Print Grade_____

Student's Name_____

Address_____ Home Tel._____

City _____ Birth Date _____

Where parents can be reached between 7:30 AM – 3 PM (work #):

Mother:_____ Tel.#1 _____
Tel #2_____
E-Mail _____

Father:_____ Tel.#1 _____
Tel #2_____
E-Mail _____

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

1. Name _____ Tel.#1 _____
   Tel #2_____
   Address _____ City_____
2. Name _____ Tel.#1_____
   Tel.#2_____
   Address_____ City_____

Date _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

Signature of parent or guardian _____

Remarks: _____

Allergies: _____

Other Conditions: _____

Local Physician's Name _____

Address _____City _____

Office Tel. No. _____ Other Tel No. _____