EPILEPSY FOUNDATION®
Not another moment lost to seizures™

SEIZURE ACTION PLAN

Effective Date_____

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name:_____ Date of Birth:_____

Parent/Guardian:_____ Phone: _____Cell:_____

Treating Physician:_____ Phone: _____

Significant medical history:_____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:_____

Student's reaction to seizure:_____

BASIC FIRST AID: CARE & COMFORT:

(Please describe basic first aid procedures)

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

If YES, describe process for returning student to classroom

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
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol: *(Check all that apply and clarify below)*
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other_____

A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication _____

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use_____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

Physician Signature:_____ **Date:**_____

Parent Signature:_____ **Date:**_____

COMMUNITY UNIT SCHOOL DISTRICT #7

ASTHMA INHALER - SELF ADMINISTRATION AUTHORIZATION FORM

TO BE COMPLETED BY PARENT/GUARDIAN:

STUDENT'S NAME _____ BIRTHDATE _____

ADDRESS _____ HOME PHONE _____

TEACHER _____ GRADE _____ EMERGENCY PHONE # _____

By signing below, I agree:

1. I authorize the School District and its employees and agents, to allow my child or ward to possess and use his/her asthma medication (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, and/or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property.
2. That when the lawfully prescribed medication is self-administered, I waive any claims I might have against the School District, its employees and agents arising out of the self administration of said medication. Illinois law requires the School District to inform parent(s)/guardians(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self administration of medication (105 ILCS 5/22-30).
3. To indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self administration of medication by the pupil.
4. That the school may contact the physician if there are problems regarding this medication.

_____ Date _____

Parent/Guardian Signature(s)

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN:

MEDICATION _____ DOSAGE _____

TIME AND FREQUENCY TO BE GIVEN _____

DIAGNOSIS _____ EFFECTIVE FROM _____ TO _____

POSSIBLE SIDE EFFECTS: _____

AS THE PHYSICIAN FOR THIS STUDENT, I VERIFY THAT HE/SHE HAS BEEN TAUGHT PROPER USE OF THEIR INHALER, HAS ADEQUATE KNOWLEDGE OF THEIR ASTHMA AND HOW TO CONTROL IT, AND IS THOUGHT TO BE RESPONSIBLE ENOUGH TO KEEP THEIR INHALER WITH THEM AND USE IT PROPERLY WITHOUT SUPERVISION.

_____

PHYSICIAN'S PRINTED NAME **ADDRESS** **PHONE**

_____

PHYSICAN'S SIGNATURE **DATE** **FAX NUMBER**

8/02

Illinois Department of Public Health
Asthma Action Plan

Patient Name _____ Weight _____ Date of Birth _____ Peak Flow _____

Primary Care Provider Name _____ Phone _____

Primary Care Clinic Name _____

Symptom Triggers _____

Asthma Severity

Green Zone "Go! All Clear!"

- Breathing is easy.
- Can play, work and sleep without asthma symptoms.

Peak Flow Range
(80% - 100% of personal best)

The GREEN ZONE means take the following medicine(s) every day.

Controller Medicine(s) **Dose**

_____

_____

_____

Spacer Used _____

Take the following medicine if needed 10-20 minutes before sports, exercise or any other strenuous activity.

_____

Yellow Zone "Caution..."

- Breathing is easy
- Cough or wheeze
- Chest is tight

Peak Flow Range
(50% - 80% of personal best)

The YELLOW ZONE means keep taking your GREEN ZONE controller medicine(s) every day and add the following medicine(s) to help keep the asthma symptoms from getting worse.

Reliever Medicine(s) **Dose**

_____

_____

If beginning cold symptoms, call your doctor before starting oral steroids.

_____

Use Quick Reliever (two - four puffs) every 20 minutes for up to one hour or use nebulizer once. If your symptoms are not better or you do not return to the GREEN ZONE after one hour, follow RED ZONE instructions. If you are in the YELLOW ZONE for more than 12-24 hours, call your provider. If your breathing symptoms get worse, call your provider.

Red Zone "STOP! Medical Alert!"

- Medicine is not helping
- Nose opens wide to breathe
- Breathing is hard and fast
- Trouble Walking
- Trouble Talking
- Ribs show

Peak Flow Range
(Below 50% of personal best)

The RED ZONE means start taking your RED ZONE medicine(s) and call your doctor NOW! Take these medicines until you talk with your doctor. If your symptoms do not get better and you can't reach your doctor, go to a **hospital emergency department or call 911 immediately.**

Reliever Medicine(s) **Dose**

_____

_____

_____

For more information on asthma, please visit the National Heart, Lung and Blood Institute at www.nhlbi.nih.gov, the U.S. Centers for Disease Control and Prevention at www.cdc.gov or the U.S. Environmental Protection Agency at www.epa.gov.

If you would like more information on Illinois' asthma program, please contact the Illinois Department of Public Health at 217-782-3300.

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ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

Child's Photograph

NAME:_____ D.O.B:___/___/___

TEACHER:_____ GRADE:_____

ALLERGY TO:_____

Asthma: ◯ Yes (higher risk for a severe reaction) ◯ No

Weight: _____ lbs

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)
SKIN: Many hives over body

Or Combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

- Call 911
- Begin monitoring (see below)
- Additional medications:
- Antihistamine
- Inhaler (bronchodilator) if asthma

Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis) → Use Epinephrine.

When in doubt, use epinephrine. Symptoms can rapidly become more severe.

MILD SYMPTOMS ONLY

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort

GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent.

IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

☐ If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.
☐ If checked, give epinephrine before symptoms if the allergen was definitely eaten.

MEDICATIONS/DOSES

EPINEPHRINE (BRAND AND DOSE): _____

ANTIHISTAMINE (BRAND AND DOSE): _____

Other (e.g., inhaler-bronchodilator if asthma): _____

MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

☐ Student may self-carry epinephrine ☐ Student may self-administer epinephrine

CONTACTS: Call 911 Rescue squad: (____)_____

Parent/Guardian: _____ Ph: (____)_____

Name/Relationship: _____ Ph: (____)_____

Name/Relationship: _____ Ph: (____)_____

Licensed Healthcare Provider Signature:_____ Phone:_____ Date:_____
(Required)

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I understand that the Local Governmental and Governmental Employees Tort Immunity Act protects staff members from liability arising from actions consistent with this plan. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Guardian Signature:_____ Date:_____

Allergy History Form

(Return to Nurse/Designated School Personnel (DSP))

Dear Parent/Guardian of: Date:

According to your child's health records, he/she has an allergy to:

Please provide us with more information about your child's health needs by responding to the following questions and returning this form to the school office.

1) When and how did you first become aware of the allergy?

2) When was the last time your child had a reaction?

3) Please describe the signs and symptoms of the reaction.

4) What medical treatment was provided and by whom?

5) If medication is required while your child is at school, the enclosed Emergency Action Plan (EAP) form must be completed by a licensed medical provider and parent/guardian.

6) Please describe the steps you would like us to take if your child is exposed to this allergen while at school.

Parent or Guardian: _____ Date: _____

Print Name: _____