HOLDINGFORD PUBLIC SCHOOLS – ISD #738
P.O. Box 250, Holdingford, MN. 56340

Dr. Chris Swenson	Angela Safran	Jim Stang	Garrity Gerber
Superintendent	Secondary Principal	Elementary Principal	Business Manager
320-746-2196	320-746-4309	320-746-4461	320-746-4306

Dear Parent/Guardian,

We are planning for the new school year and are aware that your child has a history of seizures. To ensure we have the most accurate information to care for your child, information needs to be **updated annually.** We welcome an opportunity to meet with you and to further discuss your child's diagnosis and how we can best implement a personalized school seizure management plan.

This is regarding my child, _____.

▢ **My child's seizures are no longer a concern.**
Please sign here and return this form to your child's school. No additional forms are needed.

_____ _____
Parent/guardian signature *Date*

_____
Print parent/guardian name

▢ **Seizures continue to be a health concern for my child.**

1. Either your doctor's Seizure Action Plan **or** our attached school district Seizure Action Plan must be signed by your physician and a parent/guardian. This form needs to be returned to the Health Services office as soon as possible, whether your child needs medication at school or not.
2. If medication(s) are required, they should be brought to Health Services by a parent in a current labeled container provided by your pharmacy.

Please contact Kristen Bruns, School Nurse, or Kaitlyn Thell, Assistant School Nurse, with questions or concerns, or to set up a meeting to further discuss your child's health care/emergency plan. Thank you!

Kristen Bruns, RN, LSN
School Nurse, Holdingford Public Schools
kristen.bruns@isd738.org
Elementary Health Office: (320) 746-4369

Kaitlyn Thell, LPN
Assistant School Nurse, Holdingford Public Schools
kaitlyn.thell@isd738.org
High School Health Office: (320) 746-4368

Seizure Action Plan

A physician should complete the information on this page.
A parent should complete page 2.

Student Information:

Last Name:	First Name:	Date of Birth:	Grade:	School:

Parent/Guardian Information:

Parent/Guardian #1		Parent/Guardian #2	
Last Name:	First Name:	Last Name:	First Name:
Phone #1:	Phone #2:	Phone #1:	Phone #2:

Type Of Seizures:

▢ Absence seizures (staring and decrease in responsiveness) ▢ Simple partial seizures ▢ Complex partial seizures
▢ Generalized tonic-clonic seizures ▢ Tonic seizures ▢ Drop (atonic) seizures ▢ Other (specify)_____

Seizure Information:

Date of Last Seizure: _____ **Length of Typical Seizure:** _____

Describe Typical Seizure: _____

Frequency of Seizures: ▢ Daily ▢ Weekly ▢ Monthly ▢ Other (specify) _____

Possible Triggers: _____

Student's Response After Seizures: _____

First Aid Procedure:

1. Note time the seizure begins and ends.
2. Provide a safe environment for student. Loosen tight clothing and turn on side, if able.
3. Do not place anything in student's mouth.
4. Designate someone to notify Health Services.
5. Designate someone to notify parent(s).
6. **If seizure lasts more than 5 minutes** or **back-to-back seizures occur,** designate an adult to **call 911.**
7. If seizure is less than 5 minutes, but there is **difficulty breathing,** designate an adult to **call 911.**
8. Stay with student until they have recovered. Talk with him/her. Assure him/her that everything is alright.
9. Allow student to rest after seizure.

Emergency Response:

A seizure emergency for this student is defined as:	**Seizure Emergency Protocol** ● Administer emergency medication(s) as indicated below for seizures lasting longer than _____ minutes. ● Call 911 when emergency medications are administered or if student is having difficulty breathing. ● Notify parent or emergency contact.

Medications (include daily and emergency):

Emerg. Med ✔	Medication	Dosage & time of day given	Common side effects & special instructions

Does student have a Vagus Nerve Stimulator (VNS)? ▢ **Yes** ▢ **No**
Instructions for VNS: _____

Physician's Authorization: I authorize the above plan to be followed at school.

Physician's Printed Name:	Signature:	Date:

Last Name:	First Name:	Date of Birth:	Grade:	School:

FIELD TRIPS:

- Send a copy of the Seizure Action Plan.
- If supplied by parent, emergency medication will be sent along on the field trip to be used by 911 personnel or by a staff person who has been trained by the Licensed School Nurse/RN and delegated to administer the medication.

PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Health Services of any change in the medication(s), i.e. dosage change, medication is discontinued, etc.
4. I give permission for the medication(s) to be given by school personnel as delegated by the school nurse.
5. If my child has any remaining medication(s) during or at the end of the school year, I will pick up the medication(s) from the health office.

NOTE: Medication must be supplied in the original prescription bottle.

Parent/guardian signature _____ Date _____

PARENT/GUARDIAN AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I give permission for Health Services personnel to communicate, as needed, with school staff about my child's medical condition(s).
2. I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical condition(s) being treated by the medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.

Parent/guardian signature _____ Date _____

Parent/Guardian Authorization for Action Plan: I understand that this action plan may be revoked at any time in writing, and that it expires in one calendar year. I authorize the above plan to be followed in school.

Printed Name:	Signature:	Date: