Robert Nolting
Principal

VICTOR J. ANDREW HIGH SCHOOL
9001 W. 171st Street Tinley Park, IL 60487 Phone: 708-342-5800 Fax: 708-737-7724 andrew.d230.org

Dear Parent or Guardian,

If you and/or your child's healthcare provider indicate that your child has a medical diagnosis of **Seizure Disorder/Epilepsy,** effective 1/1/2020, the State of Illinois requires all school districts to request that you submit a current Seizure Action Plan completed by the treating healthcare provider for a student who seeks assistance with epilepsy-related care in a school setting. This plan will be kept in your child's health file in the School Health Services Office. This new law also requires that the Seizure Action Plan be updated each school year.

For your convenience, a blank Seizure Action Plan can be found on the following link under Important Documents (https://www.d230.org/Page/1332). Please bring this form to your healthcare provider to complete. The form must also be signed by the student's parent or guardian. We can also accept a Seizure Action Plan Form that is provided by your physician.

You can return the completed Seizure Action Plan in one of the following manners:

- Send to school with your student and have them bring it to the Nurse's Office
- Drop off the form at the VJA Main South entrance security desk
- Upload the completed form to Laserfiche https://lf.d230.org/Forms/Medical

Thank you for your prompt attention to this important request.

Sincerely,

Teri Shiley RN

Teri Shiley MA, RN, PEL-CSN
Illinois Professional Educator License-Certified School Nurse
Victor J. Andrew High School
Office: 708-342-5858
Fax: 708-737-7725

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

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 _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

Epilepsy.com

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EPILEPSY FOUNDATION

END EPILEPSY