



Notice to parents/guardians re: Seizure Action Plan

While Lakeside School is a private institution, we voluntarily adopt the standard of safety outlined in the law applicable to public schools (RCW 28A.210.320) concerning children with life-threatening conditions, reflecting our commitment to maintaining a similar level of safety and care for our students. 'Life-threatening conditions' refer to those posing a danger to a child's life during the school day without a valid medication or treatment order ("Action Plan"). **Please ensure your student possesses the necessary medications as outlined in the Seizure Action Plan either on their person or securely stored with the school nurse in the Health Room on or before the first day of summer programs/camp.** If a student with such a condition lacks this documentation and medication at summer programs/camp, Lakeside's summer administration is required to exclude them until the necessary documentation and medication is provided. Providing the appropriate Action Plan grants Lakeside's School Nurse authority, as mandated by law under RCW 18.79.260(2), to administer required care.

The **"Seizure Action Plan"** substitutes the **"Medication at Lakeside School"** form if a student solely needs seizure medication at school. For students needing non-seizure medications, like over the counter or prescription drugs, alongside seizure management, both the "Medication at Lakeside School" form and the "Seizure Action Plan" should be completed. The "Seizure Action Plan" addresses seizure-specific medication needs, while the "Medication at Lakeside School" form encompasses a broader range of medication requirements. Parents and guardians are advised to complete the appropriate form based on the student's specific medication needs. **"Seizure Management Care Plan" from the student's neurologist will be accepted in lieu of the attached form, if desired.**

Forms can be found on Summer at Lakeside Health & Safety page and submitted on CampBrain. If your child has seen their doctor within the last year, *you likely do not need to make an additional appointment to get this form filled out.* Try calling your doctor's office or using MyChart to ask for the completion of the below form.

We appreciate your cooperation in implementing this change to prioritize the safety and well-being of your student.

Lakeside School 14050 1st Ave NE Seattle, WA 98125	Lakeside Middle School 13510 1st Ave NE Seattle, WA 98125
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ATTENTION:	Joy Irvin, School Nurse
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FAX:	MS: (206)368-3639 US: (206)368-2638
EMAIL:	joy.irvin@lakesideschool.org

SEIZURE ACTION PLAN (SAP)



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: _____