Student Name_____ Attachment E

Transportation Office Use ONLY if needed
Bus # _____ Driver: _____ Route # _____ Medical File _____

Madison District Public Schools
SEIZURE Medical Action Plan (MAP)

Student Picture
Face only

Student's Name _____
Date of birth_____ **School** _____
Age _____ **Grade**_____ **Teacher**_____

Page one of this MAP is to be completed signed and dated by a parent/guardian.
Page two of this MAP is to be completed, signed and dated by the treating physician/licensed prescriber.
Without signatures this MAP is not valid. The parent/guardian is responsible for supplying all medication & any other supplies required.

CONTACT INFORMATION

		Call First	**Try Second**
Parent/ Guardian:	Name:	_____	_____
	Relationship:	_____	_____
Phone:	Home:	_____	_____
	Cell:	_____	_____
	Work:	_____	_____

Call Third (If a parent/guardian cannot be reached)
Name:_____ Relationship:_____
Address: _____ Phone: _____

SEIZURE HISTORY

Seizure Type (please check all that apply)
Generalized: □ **Tonic Clonic** (grand mal) □ **Atonic** (drop attacks) □ **Myoclonic** □ **Absence** (petit mal)
Partial: □ **Simple** □ **Complex** (psychomotor/temporal lobe)
Other or Description of seizure_____

How long does a typical seizure last_____**How often do seizures occur**_____**Date of last seizure**_____

Warning signs (aura) or triggers if any, please explain_____

Age when seizures were diagnosed_____**Date of last exam for this condition**_____

Student on ketogenic diet □ YES □ NO Past history of surgery for seizures □ YES □ NO
Student's reaction to seizure _____
Does student need to leave the classroom after a seizure? □ YES □ NO
If yes, describe process for returning to classroom _____
Notify parent immediately for all seizure activity □ YES □ NO
Other instructions_____
Any special considerations or safety precautions:
_____

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having seizures to better identify needs. I give permission to use my child's picture on this plan (if I did not supply a photo.) I give permission for trained staff to administer any medication ordered for seizure activity in this 2 page plan and to contact the ordering physician/licensed prescriber for clarification of this plan if needed.
□**YES** □**NO** I have read the attached information regarding section 504 eligibility
□**YES** □**NO** I wish to be contacted regarding a 504 evaluation

Parent/Guardian Signature_____Date_____

Action if student has a seizure

- **Stay calm & track time**
- **Keep child safe**
- **Do not restrain**
- **Do not put anything in mouth**
- **Stay with child until fully awake**
- **Record seizure in a log**

In addition for tonic-clonic (grand mal) seizure

- **Keep airway open/monitor breathing**
- **Protect head**
- **Turn child on side**
- **Follow medical orders (below)**
- **Follow directions of parent (page one of MAP)**

General Signs of a Seizure EMERGENCY

- **Convulsion (tonic-clonic/grand mal) longer than 5 minutes** or per 911 instructions below in Order
- **Student has repeated seizures (starts another seizure right after the first)**
- **Student is injured or has diabetes**
- **Student has breathing difficulties**
- **Student has a seizure in water**

Action

CALL 911

- ✓ **Stay with the student until help arrives**
- ✓ **Call parent/guardian**
- ✓ **CPR if needed**

Location(s) of Emergency Medication (if ordered below) in the school:

_____

Physician/Licensed Prescriber Order & Agreement with Protocol (as outlined in this 2 page plan)

☐ **Administer Diastat® rectal gel for seizure lasting longer than_____minutes. Dose_____**
See package instructions. Other instructions: _____

☐ **Administer_____for a seizure lasting longer than_minutes. Dose_____**
Administration instructions_____
Other instructions_____

Does student have a Vagal Nerve Stimulator ☐ YES ☐NO (if YES, please describe magnet use)

_____

Call 911 if: (please check and complete)

- ☐ **Seizure does not stop by itself within_____minutes**
- ☐ **Anytime medication is given to stop a seizure**
- ☐ **Only if seizure does not stop within_____minutes after giving medication**
- ☐ **Other directions:**

_____

Physician/Licensed Prescriber's Name_____

Phone number_____FAX number_____

Signature_____Date_____

MADISON
DISTRICT PUBLIC SCHOOLS
Serving Families One Student at a Time

NOTICE OF SECTION 504 PROCEDURAL SAFEGUARDS FORM C

The following is a brief summary description of the rights provided by Section 504 of the Rehabilitation Act of 1973 to students with disabilities, or suspected disabilities, and some related rights provided by Title VI of the Civil Rights Act of 1964 and the Family Educational Rights and Privacy Act. The intent of the law is to keep you fully informed about decisions concerning your child and to inform you of your rights in the event you disagree with any decisions concerning your child. You have the right to:

1. have the District advise you of your rights under federal law;

2. receive notice with respect to Section 504 identification, evaluation, and/or placement of your child

3. have an evaluation and placement decision for your child based upon information from a variety of sources and which is made by a team of persons knowledgeable about the student, the meaning of evaluation data, and placement options;

4. have your child receive a free appropriate public education, which is the provision of regular or special education and related aids and services that are designed to meet individual educational needs of your child as adequately as the needs of students without disabilities are met, if the child is Section 504 eligible;

5. have your child be educated with non-disabled students to the maximum extent appropriate, if the child is Section 504 eligible;

6. have your child take part in and receive benefits from the District without discrimination on the basis of disability;

7. have your child educated in facilities and receive services comparable to those provided to non-disabled students;

8. examine all relevant records of your child, including those relating to decisions about your child's Section 504 identification, evaluation, educational program, and placement; and obtain copies of those records at a reasonable cost, unless the fee would effectively deny you access to the records;

9. receive information in your native language and primary mode of communication;

I 0. have a periodic re-evaluation of your child, including an evaluation before any significant change of placement;

1 1. have your child given an equal opportunity to participate in nonacademic and extracurricular activities offered by the District;

12. request and participate in an impartial due process hearing regarding the identification, evaluation, or placement of your child, including a right to be represented by counsel in that process and to appeal an adverse decision;

13. file a complaint in accordance with the District's grievance procedures or with the U.S. Department of Education, Office for Civil Rights.