SEIZURE ACTION PLAN

To be filled out by Parent or Guardian

CITY OF BLOOMINGTON MINNESOTA PARKS AND RECREATION

HH #: _____

★ **Forms that were completed for your child's <u>current</u> school year with a physician signature may also be submitted in place of this form.** ★

The City of Bloomington, Parks and Recreation intends to use the requested information to provide for your child's health and safety while at programming. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health plan for your child. The information you provide will be shared only with staff in the program whose jobs require access to this information to ensure your child's safety.

Effective Year: _____

PARTICIPANT

FIRST NAME: **LAST NAME:**

BIRTH DATE: ___Male   ___Female

HOME PHONE: **CELL #:**

Treating Physician: Phone:

Significant Medical History:

SEIZURE INFORMATION

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Participant's reaction to seizure:

BASIC FIRST AID: CARE & COMFORT

Does participant need to leave the program after the seizure?   ____ YES   ____ NO

If YES, describe process for returning participant to program:

Basic Seizure First Aid:
√ Stay calm & track time
√ Keep participant safe
√ Do not restrain
√ Do no 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 for breathing
√ Turn participant on side

TREATMENT PROTOCOL DURING PROGRAM HOURS: (include daily & emergency medications*)

Daily Medication*	Dosage & Time of Day Given	Common side effects & special instructions

Emergency/Rescue Medication:

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

If YES, describe magnet use:

List any special considerations & safety precautions:

A seizure is generally considered an emergency when::

√ A convulsive (tonic-clonic) seizure lasts longer than 5 min.

√ Participant has repeated seizures without regaining consciousness

√ Participant has a first time seizure

√ Participant is injured or has diabetes

√ Participant has breathing difficulties

√ Student has a seizure in water

OVER ➡

*If medication is needed, complete the Medication form.

SEIZURE ACTION PLAN

CONFIDENTIAL

★ **Forms that were completed for your child's _current_ school year with a physician signature may also be submitted in place of this form.** ★

It is the guideline of Bloomington Parks and Recreation to call 911 if: the seizure lasts more than 3 minutes unless we are directed to do otherwise by the parent/guardian, or if the participant stops breathing for more than 30 seconds.

RETURN TO: City of Bloomington, Parks & Recreation, 1800 W. Old Shakopee Rd, Bloomington, MN 55431

Please do not forget the necessary signatures below.

Effective Year: _____

Physician Signature: **Date:**
Only necessary if medication or treatment needed at program

Form Completed by:

Relationship to Participant:

Date: **Phone:**

The Data Practices Act requires that we inform you or your rights about the private data we are requesting on this form. Private data is available to you, but not to the public. This information can be shared with the Bloomington Parks and Recreation staff. You can withhold this data, but you may not receive updated program information and/or accommodations. Your signature on this form indicates you understand these rights.

Signature of legal guardian REQUIRED

SIGNATURE: _____ **DATE:** _____

OFFICE ONLY: Received on _____ (date) by _____(Staff)

                          RecTrac updated? Y / N   Plan Created? Y / N

                          Parent/Guardian contacted? Y / N   P/G contacted on _____ (date)