RE: Seizure Action Plan fax # (812) 274-8791

Date: _____
Student Name: _____ DOB: _____

Dear Parent or Guardian,

Our records indicate that your child has a seizure disorder. To ensure your child receives appropriate accommodations and care at school, we require an updated physician-approved seizure action plan.

Please complete the following steps:

1. Physician Review: Please have your child's physician review, complete, and sign the attached form.
2. Return to School: Return the signed form to the school office, along with any prescribed emergency medication.
3. Health Care Planning: To develop an accurate Individualized Health Plan (IHP) for your child, I would like to schedule a brief phone consultation with you to discuss their specific needs. Please call the school to leave a message with your preferred call-back time.

Important Reminders:

- If you do not have an upcoming appointment, your physician may fax this completed form or their own action plan directly to us at (812) 274-8791.
- Health care plans must be updated annually to ensure your child's safety.

If you have any questions or concerns, please feel free to contact your School Nurse

Thank you for your partnership in keeping your child safe and supported at school.

Sincerely,
Renee James, RN
District Nursing Coordinator

RJ 2026

## Seizure Emergency Action Plan

Student Name:_____ Date Of Birth:_____
School: _____ Grade: _____ Teacher: _____
Scheduled Bus:_____ Bus Driver: _____ Bus Aide:_____

Seizure Type:_____
Description: _____
_____
_____

Treatment

- PRN Seizure Medication:_____
  - Route: _____
  - Seizure >_____ minutes or for _____ or more seizures in _____hours
- Use VNS (vagal nerve stimulator)
- Call 911 if
  - Seizure does not stop by itself or with VNS within _____ minutes
  - Seizure does not stop within _____ minutes of giving emergency med
  - Student does not start waking up within _____ minutes after seizure is over (no med given)
  - Student does not start waking up within _____ minutes after seizure is over (after emergency med given)
- Following a seizure
  - _____ Students should rest in nurses office
  - _____ Parent/Guardian should be notified immediately
  - _____ Student may return to class
  - _____ Parents/caregivers should receive a note/copy of the seizure record send home with the child

Physician Name (Printed)_____
Physician Phone Number_____ FAX_____

Physical Signature_____ Date_____

**PLEASE HAVE THIS FORM FILLED OUT BY YOUR PHYSICIAN AND RETURNED TO SCHOOL. FAX 812 274 8791**

**Emergency Contact Numbers**
**1: Name:_____ Number: _____**
**2: Name: _____ Number: _____**

RJ 2026

# MADISON CONSOLIDATED SCHOOLS STUDENT INDIVIDUALIZED HEALTH CARE PLAN

Includes applicable physician orders and EAPs
(emergency action plans)

**SCHOOL YEAR: 2026-2027**

| **STUDENT INFORMATION:** 504 Plan Yes.___ No____ **ALLERGIES:** _____ | | | |
|---|---|---|---|
| **Student:** | D.O.B. | **Grade:** | **School:** |
| **Counselor:** | **BUS:** | | **Driver:** |
| **Parent:** | **Phone:** | | **Email:** |
| **Physician:** | **Phone:** | | **Fax:** |
| **Physician:** | **Phone:** | | **Fax:** |
| **School Nurse:** | **School Phone:** | | **Fax:** |

| **Medical Diagnosis:** |
|---|
| |

| Daily Medications | Notable side effects | Time of Admin |
|---|---|---|
| | | |
| | | |
| | | |

| Symptom(s) of Concern: | Intervention: |
|---|---|
| | |
| | |

| Goals: | Evaluation: |
|---|---|
| | |
| | |

| DIET: | ACTIVITY: | ENVIRONMENTAL MODIFICATIONS: |
|---|---|---|
| | | |

**SCHEDULE OF DAILY CARE:**

| | |
|---|---|
| **Breakfast** | |
| **Lunchtime**: | |
| **Afternoon:** | |

**FIELD TRIP/EXTRA-CURRICULAR ACTIVITY CONSIDERATIONS:**

**CONTINGENCY PLANNING:** (Who will provide care in event of the nurse absence)

| Trained VHA: | Sub Nurse | Health Room Assistant |
|---|---|---|
| Yes or No | Yes or No | Yes or No |

**SUPPLIES NEEDED: Parents will provide all needed supplies for treatments and orders i.e wipes, diabetic supplies, snacks or food, emergency meds,cath supplies, gtube supplies, etc.**

"I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my licensed healthcare provider if necessary, and for this healthcare information to be shared with pertinent school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices."

RN Signature:_____Date: _____

Parent Signature: _____ Date: _____




# AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION 2026/2027

Student Name: _____ DOB: _____
Parent or Legal Guardian:_____Phone: _____
Address: _____ City/State/Zip: _____
School: _____Grade: ___ Teacher: _____

Medical Condition(s): _____
_____

Authorization for the exchange of information is hereby granted between Madison Consolidated Schools and the following agency(s) and/or individual(s):

1._____ _____
Name of physician, agency, individual, etc. Phone Fax

2._____ _____
Name of physician, agency, individual, etc. Phone Fax

3._____ _____
Name of physician, agency, individual, etc. Phone Fax

Effective: 2026-2027 School year
Purpose: The purpose of the use and/or disclosure of this information is to best provide for the student's educational, physical and emotional adjustment between the hospital/ Medical office setting and the school setting.

Treatment Orders:____ Emergency Action Plans _____Health/Medical Record Information: _____

• This authorization is valid for twelve (12) months from the date of signing. At any time, I may revoke this release in writing. If I want it to expire on a different date, then that date is:___ . Revocation does not affect release of medical records made prior to the revocation. I understand that I have a right to receive a copy of this form after signing.
• I recognize that these records, once received by the school district, may not be protected by the Health Insurance Portability and Accountability Act (HIPAA), but will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

• Signing this release is voluntary. Refusing to sign it will not affect the school or district's commitment to provide a quality education for the student. However, the requested records may be required in order for the school to implement an appropriate plan of education, learning accommodations/modifications, and or health care.
• I understand for the purpose of providing the most appropriate instruction and assistance in school, I am giving my permission for mutual exchange of educational evaluations or medical evaluations.
• Parents of a student with a disability have protection under the procedural safeguards described in the law: 511 IAC-7-37-1. If I have not previously received a copy of written notice of procedural safeguards and a list of resources for help in understanding my rights, I understand these can be obtained from my child's teacher or the Special Education office.
• By my signature below, I indicate that I am the parent or legal guardian of the above named child. I authorize the release and use of the information in accordance with the rights,restrictions and understandings above to ensure health, safety and continuity of care for my child.

Parent or Legal Guardian's Signature: Date:

_____ _____