Bernards Township Public Schools
101 Peachtree Road
Basking Ridge, New Jersey 07920

Dear Parent and/or Guardian,

The State of New Jersey has recently passed legislation, "Paul's Law," that authorizes a parent or guardian of a student with epilepsy or a seizure disorder to request use of an individualized health care plan. This individualized health care plan must be developed for each student by the school nurse. The plan will be consistent with the recommendations of the student's health care providers and will outline a set of procedural guidelines that provide specific directions about what to do in an emergency.

Bernards Township School Nurses have already been utilizing Individual Health Plans they design for students with seizures or epilepsy based on the information that you, as parent/guardian, submit from your child's neurologist on their Seizure Action Plan annually. It is our highest priority to provide for the health of your child. We are now requesting your permission to share this information with school staff and bus drivers as appropriate, in compliance with this new N.J. law.

Paul's Law requires that school staff and school bus drivers be provided with education related to seizure disorders as well as information specifically naming each student with a seizure disorder. With your consent, the school nurse would provide the student's name, information about their disorder, how to provide first aid care, and emergency contact information to any school staff and bus driver involved with your child.

As a reminder, students with any seizure disorder are required to submit a Seizure Action Plan, signed by you and a physician, including any medical orders and any medications that need to be administered during the school day, to the school nurse on the first day of school each year.

Please complete and return the enclosed consent form to your child's school nurse as soon as possible. We will not share this important information without your consent. If you have not yet submitted a Seizure Action Plan this school year, please do so now. If you have any questions or concerns, please contact your child's school nurse to discuss.

Bernards Township School Nurses

References: Paul's Law: https://www.nj.gov/governor/news/news/562020/approved/20200109c.shtml

https://www.njleg.state.nj.us/2018/Bills/S4500/4141_I1.HTM

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Date: _____

Student Last Name: _____ First Name: _____

School: _____ Grade: _____

Seizure Action Plan Submitted to School Nurse:

_____ Previously submitted for current school year

_____ Attached here for current school year

Consents:

I give my permission for the Bernards Township School District, in an effort to provide for the health care of my child, to share medical information with other healthcare providers, school staff and bus drivers as necessary. **Please initial all that apply**:

_____Yes, please provide information naming my child and their seizure disorder to school staff.

_____Yes, please provide information naming my child and their seizure disorder to my child's bus driver.

_____No, I do not wish to have my child's name or medical information shared with anyone at this time.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____ Relationship to Student: _____

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Date: _____

Student Name: _____ Grade in Fall: _____

DOB: _____ Student's School _____

Dear Parents:

We are aware that your child has a medical history of being prescribed Diastat for seizures. In an effort to plan for the appropriate care and staffing for the next school year, we request that you and the treating neurologist complete the following and submit to the school nurse by May 30th:

- Neurologist Annual Exam Note (Neurologist completes)
- Neurologist Order/Seizure Action Plan for Diastat (Neurologist completes)
- Student Seizure/Diastat Assessment (Neurologist completes)
- Medication supplied by September 1st to school nurse (Parent responsibility)
- Notification of participation in any extracurricular activity (Parent responsibility)

Parents are responsible for informing the school district in advance if a student requiring Diastat intends to participate in any extracurricular activity or is being bused to and from school, i.e., (Busing, Clubs, Before Care or After Care, Mini Units, Athletics, Unified Sports, etc.) to ensure that appropriate safety measures are in place. Please notify the school nurse of any program outside of the regular school day hours that you are considering as we typically would NOT have an RN available.

Our highest priority is to assure that your child is appropriately cared for. As you can imagine, it can be a challenge to find professional staff to be available after school hours for Diastat provision. **If your physician does not believe that there is a need to provide for Diastat in an extracurricular or off site activity (having an RN present), we would request a letter stating such.** The letter should be signed by both the treating neurologist and a parent.

Any Diastat order/Seizure Action Plan must be accompanied with the prescribed medication and provided to the school nurse on the first day of school. We thank you for your anticipated cooperation.

Dr. Matthew Speesler, District Physician

Bernards Township School Nurses

Bernards Township Public Schools

101 Peachtree Road
Basking Ridge, New Jersey 07920

Student Seizure/Diastat Assessment

Date: _____

Student Name: _____ Grade in Fall: _____

DOB: _____ Student's School: _____

This form must be completed by the treating neurologist and submitted to the School Nurse along with the Seizure Action Plan and annual neurologist exam note by May 30th of each school year in preparation for the start of next school year.

Student has a prescription for Diastat administration during school hours: **YES or NO**

Student requires Diastat to be available for busing to and from school: **YES or NO**

Student may participate in activities off-campus or outside of regular school hours without a school nurse present (911 would be called for any seizure activity): **YES or NO**

Student may participate in swimming program after 12 mos. seizure-free: **YES or NO**

Seizure Action Plan is attached. **YES or NO**

Please indicate below as applicable for student's Diastat order:

Date of last neurological exam: _____ (Please attach neurology note)

Date of last seizure: _____Type of Seizures: _____

Relevant EEG finding:

Related hospitalization:

List any anticonvulsant medications: (Name, dose, frequency)

Please Note: Parent is responsible for providing prescribed medication and informing School District in advance for any busing or extracurricular activity i.e., (Busing Clubs, Before Care, After Care, Mini Units, Athletics, Unified Sports, etc.) to ensure that appropriate safety measures are in place.

Neurologist Name: _____ Signature: _____

Reviewed by School Physician: _____ Date:_____

Reviewed by School Nurse: _____ Date: _____

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse 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 student 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 _____

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