



**School Health Program**

**Skills Checklist for Delegation to Unlicensed Assistive Personnel: Seizure Disorder**

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**School Nurse:** \_\_\_\_\_ **Date of Training:** \_\_\_\_\_

**Trainee Name:** \_\_\_\_\_ **Position:** \_\_\_\_\_

The trainee has demonstrated understanding and competency consistently to:

SKILLS	YES	NO	COMMENTS
Identifies seizure triggers for student			
Identifies signs and symptoms of seizure episodes			
States the use of medication: A. Correct name and expiration date B. Side effects C. Adverse reactions D. Appropriate use of medication per order			
States safety precaution measures			
Identifies the location and content of the Emergency Action Plan			
State when to call 911			

**Trainee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I hereby acknowledge that the person listed above has demonstrated all the above listed skills.

**School Nurse Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Review Dates:** \_\_\_\_\_