Health Care Action Plan - Seizure

Please return form to: Resurrection Christian School Fax: 970 647 7385

Student Name _____ DOB _____ Grade _____

Emergency Contact Information

List contacts in order of preference. Also, write preference of contact method, 1 being the highest, 3 the lowest:

Contact #1 Name: _____ Contact #2 Name: _____

Home Phone: _____ Preference:____ Home Phone: _____ Preference:____

Cell Phone: _____ Preference:____ Cell Phone: _____ Preference:____

Work Phone: _____ Preference:____ Work Phone: _____ Preference:____

Specialist: _____ Phone: _____

Diagnosis:_____

Symptoms and History of Seizures (include age at time of onset, how long, what precipitates, and aura)

Description of Seizure

Medication Provided to School for Treatment of Seizure

Restrictions/Precautions

Interventions:

1. Time seizure and be able to describe the seizure (type, body parts involved, incontinence, disorientation period).
2. Ease to the floor. Loosen collar and any binding clothes.
3. Do not restrain. Keep from hurting self by moving furniture and objects away from person.
4. Place on side to accommodate flow of saliva and maintain an open airway
5. Do not place a tongue blade or any other object in mouth
6. If seizure activity ceases and child is able, then assist to Health Office for rest.
7. If seizure lasts beyond five minutes, call 911, school nurse, and staff (unless otherwise outlines above).

I give permission for the information contained on this HCAP to be shared with adults in the school settings that will be working with my child on a need-to-know basis. This HCAP will remain in effect for one school year or until the health status of physician's orders change. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care.

Health Care Provider (MD/DO/NP/PA) Date Parent/Guardian Date School Nurse Date

Seizure Emergency Care Plan and Medication Orders for School and Childcare Settings

PARENT/GUARDIAN complete and sign the top portion of form.		Place child's photo here
Child Name:	Birth date:	
Parent/Guardian Contact:	Phone:	
Emergency Contact:	Phone:	
School:	Grade:	

Triggers: ☐ tiredness ☐ flashing lights ☐ illness ☐ hunger ☐ temperature ☐ Other: _____
Seizure Aura (if any) _____
Seizure history: ☐ Convulsive ☐ Focal ☐ Absence Date of last known seizure _____
Describe _____

Antiseizure Medication Taken at Home	**Common side effects**

Other Seizure Treatments/Special Diet Therapy:

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and devices. I approve this Seizure Emergency Care Plan for my child.

_____ _____ _____ _____ ☐ 504 plan ☐ IEP
PARENT SIGNATURE DATE SCHOOL NURSE SIGNATURE DATE

HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.

IF YOU SEE THIS:	**DO THIS:**
☐ **Convulsive Generalized Tonic Clonic**: You will see loss of consciousness. Stiffening of the body. Rhythmic jerking movements. Convulsive seizures may last 1-5 minutes. The child may have a warning (aura) before the seizure. Sleepiness and confusion may occur after the seizure.	1. Time the seizure 2. Keep calm. Provide reassurance. 3. Protect head, keep airway clear, turn on side if possible. 4. Do not place anything in mouth. 5. Call 911 if student is injured or has difficulty breathing. 6. Call parent. 7. Stay with student until recovered from seizure. 8. **Administer rescue treatments as marked below.**
☐ **Focal**: These seizures may begin with an aura. They may be partly alert or unconscious. You may see lip smacking, chewing, eye blinking, or picking at clothes. These seizures usually last 1-2 minutes. ☐ **Absence**: You will see quick changes in alertness. May see eye flutter or small twitching. Usually last less than 10 seconds.	1. Time the seizure 2. Gently guide child away from danger. 3. Stay with student and reassure them until recovered from seizure. 4. Do not treat staring that is stopped by a touch or a nudge. 5. Call parent. **6. Administer rescue treatments as marked below.**

Rescue Treatments

☐ Child has a VNS. Child/staff may swipe with aura. Staff may swipe at onset of seizure and every 60 seconds until seizure stops. Give rescue medications below if seizure does not stop within _____minutes.

If seizure lasts longer than ___ minutes administer:

☐ Diastat ___mg rectally	☐ Midazolam ___mg in the nose	☐ Clonazepam ___mg in the cheek

☐ Multistep seizure rescue plan – Please see attached letter for details.

If cluster of ___ or more seizures in _____ min administer:

☐ Diastat ___mg rectally	☐ Midazolam ___mg in the nose	☐ Clonazepam ___mg in the cheek

☐ Multistep seizure rescue plan – Please see attached letter for details.

If emergency medication is administered: ☐ Call 911 immediately or ☐ Call 911 if seizure does not stop within 5 minutes
Other:

If no emergency medication is at school and the child is experiencing seizures:
Call family to bring medications to school or pick up child. Call EMS if seizure lasts more than ___ min

Accommodations: Always take seizure action plan and emergency medication for school activities, sports and field trips. Close adult supervision when swimming or climbing.

_____ _____ _____ _____
HEALTH CARE PROVIDER SIGNATURE PRINT PROVIDER'S NAME PHONE/FAX DATE