SEIZURE CARE PLAN AND MEDICATION ORDERS: Plan ___ of ____

NAME		Birthdate:	School:		
Grade	Preferred Hospital	☐ Bus #	☐ Walk	☐Drive	Weight
History (including current medication)					

TYPES of SEIZURES		
Tonic Clonic	**Absence**	**Psychomotor**
Muscles tense, body rigid, followed by a temporary loss of consciousness and violent shaking of entire body. **Comments**	Staring spells. May drop an object s(he) is holding or may stumble momentarily. **Comments**	Some degree of impairment of consciousness-- may have automatic movements like lip smacking, roaming, and non-goal oriented activity. **Comments**
*IDENTIFY students usual signs/symptoms	*IDENTIFY students usual signs/symptoms	*IDENTIFY students usual signs/symptoms

IF YOU SEE THIS	DO THIS Adult stays with student at all times
ABSENCE AND PYSCHOMOTOR SEIZURES	Time seizure and monitor student closely. Notify the nurse and parent/guardian_____. Gently support and protect student from harm. Do not restrain. No first aid is needed if no injury. After seizure, calmly re-orient student to their surroundings. After seizure, record seizure activity on Seizure Observation Log.
TONIC CLONIC Do not hold student down Do not put anything in their mouth (for loss of bowel/bladder, cover with blanket for privacy)	Time seizure activity. Stay calm & ease student to floor to avoid a fall. If trained, administer medication/treatments as ordered below. Clear area around student-move hard objects. Keep others away. Support student on their left side to allow vomit/drool to drain. Loosen clothing around neck. Place soft material under head. Notify the nurse_____and parent/guardian_____. After seizure record events on the Seizure Observation Log.

CALL 911 IF:

- Seizure does not stop by itself or is 1st tonic clonic seizure
- Seizure does not stop within_____minutes
- Child does not start waking up within_____minutes after seizure is over
- Another seizure starts immediately after the first seizure
- Bluish color to lips AFTER seizure ends
- Prolonged loss of consciousness
- Stops breathing **(START RESCUE BREATHING/CPR)**

MEDICATION ORDERS

- For seizure lasting over _____minutes **OR** for_____or more _____(type) seizures in_____minutes/hours **OR**
- Child does not start waking up within_____minutes after seizure is over
- _____ (medication) _____mg _____ (route) for _____(type)
  for intra-nasal midazolam: give _____ml divided---1/2 dose (_____ml) into each nostril
- Call 911 when seizure emergency medication has been administered
- Daily seizure medication: _____ Dose: _____ Time: _____
  ☐ Takes seizure medication at home ☐ Takes seizure medication at school
- ☐ **NO MEDICATIONS HAVE BEEN ORDERED**

LHP Signature	Date	Telephone Fax Number
LHP Printed Name	Start Date	End Date

Document seizure activity on Seizure Observation Log (attached)

EMERGENCY CONTACTS

Name:
Primary #
Other #
Other #

Parent/Guardian

Name:
Primary #
Other #
Other #

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Accommodations needed _____ No _____ Yes If yes, list below:

- A new EAP and medication/treatment orders for seizures must be submitted each school year.
- If any changes are needed on the EAP, it is the parent/guardian's responsibility to contact the school nurse.
- It is the parent/guardian's responsibility to alert all other **non-school** programs of their child's health condition.
- Medical information may be shared with school staff working with my child and EMS staff, if they are called.
- I have reviewed the information on this Seizure Emergency Action Plan/504 and medication/treatment orders and request/authorize trained school employeesto provide this care and administer medication/treatments in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- This is a life-threatening plan and can only be discontinued by the LHP.
- I authorize the exchange of information about my child's seizure disorder between the LHP office and the school nurse.
- *My signature below shows I have reviewed and agree with this health care/504 plan and medication/treatment orders.*

Parent/Guardian Signature Date

EXPECTED POST-SEIZURE BEHAVIOR

- Tiredness
- Weakness
- Sleeping
- Difficult to arouse
- May be somewhat confused
- Regular breathing
- This period may last a few minutes or hours

For District Nurse's Use Only **☐ 504 Plan**

A registered nurse has completed a nursing assessment and developed this Seizure Care Plan in conjunction with this student, their parent/guardian and their LHP.

Medication/Device(s)	**Expiration date(s)**

School Nurse Signature	**Date**	**Phone**

Health care/504 plan and medication (if prescribed) must accompany student on any field trip or school activity.

***** Keep plan readily available for Substitutes. *****