Madison School District 321

Seizure Action Plan

Individualized Health Care Plan (IHC)

School Year	Student Picture
School:	
Grade:	

STUDENT INFORMATION

Student:		DOB:
Parent:	Phone:	Email:
Parent:	Phone:	Email:
Healthcare	Phone:	Fax:
District Nurse: Kim Ward, RN	Phone: (503) 871-2834	Fax: 208-359-3370

SPECIAL CONSIDERATIONS

Special considerations and precautions (regarding school activities, field trips, sports, etc.):

SEIZURE EMERGENCIES. CALL 911

First time seizure	**Food is aspirated (blocking airway)**	**Repeated seizures**
Student with Diabetes	**Breathing difficulties**	**Seizure > 5 minutes**
Student who is pregnant	**Different seizure type than student's usual**	**Head injury**
Seizure occurs in water	**Consciousness is not regained**	**other:**

SEIZURE EMERGENCY MEDICATION (Please attach Seizure Emergency Medication/Management form)

This student has a Seizure Emergency Medication ○ yes ○ no

Location of Medication:__________________________

VAGUS NERVE STIMULATOR (Please attach Seizure Emergency Medication/Management form)

This student has a Vagus Nerve Stimulator (VNS) ○ yes ○ no

Location of the magnet:__________________________ Location of VNS on student's body:__________________________

SEIZURE INFORMATION (please check all seizure categories that apply to this student)

○ *Tonic Clonic (Grand Mal)*

Triggers	Length	Frequency

If you see this:

- Sudden hoarse cry or shout
- Loss of consciousness
- May fall if standing
- Muscles become stiff (tonic)
- Convulsions or stiffening of extremities followed by rhythmic jerking (clonic)
- Shallow or irregular breathing
- Occasionally cyanotic (blue skin, nails, lips)
- Drooling/Vomiting
- Biting the tongue or inside of the mouth
- Loss of bladder and bowel control
- other:______________________________________

Do this:

- Time the seizure
- Gently guide the student to the floor
- Cushion head with something soft
- Remove harmful objects
- DO NOT put anything in mouth
- DO NOT restrain
- Place in rescue position/protect airway
- Explain/reassure others
- Protect student's privacy
- After the seizure is over, reassure/reorient
- Do not leave student alone
- Record on Seizure Observation Record
- other:______________________________________

○ *Absence*

Triggers	Length	Frequency

If you see this:

Blank stare or lapse of awareness
Mistaken for daydreaming, inattentiveness, or ignoring

Talk to student and touch their shoulder.
If they respond, less likely to be a seizure
other:______________________________________

Do this:

Time the seizure. Usually only 5 - 10 sec
Speak softly/reassure/reorient
Explain/reassure others

Do not leave student alone
Record on Seizure Observation Record
other:______________________________________

○ *Focal Onset (Simple Partial)*

Triggers	Length	Frequency

If you see this:

Only one part of brain is involved so consciousness is not impaired
Student is aware
Experience sensory symptoms like tingling, numbness, sounds, smells, visual distortions
Twitching or smacking lips

Experience psychic symptoms, like deja-vu, hallucinations, fear, anxiety, or feelings they can't explain
May be confused with acting out or psychological problems
Eyes or head turned to the side
other:______________________________________

Do this:

Time the seizure. Usually < 2 min.
Speak softly/reassure/reorient
Explain/reassure others

Record on Seizure Observation Record
Do not leave student alone
other:______________________________________

○ *Focal Impaired Awareness (Complex Partial)*

Triggers	Length	Frequency

If you see this:

Consciousness may be affected in some way
Student may be partially aware, dazed, or confused
Wandering, fumbling, getting in someone's "bubble"
Lip smacking, picking at clothes

Non-sensical speech, difficult to understand, or talking jibberish
Confused with being drunk, drug abuse, or aggressive behavior
other:______________________________________

Do this:

Time the seizure. Usually 1 - 2 min.
Do not expect verbal instructions to be obeyed
Gently guide student away from potential hazards

Do not restrain or the student may become combative
Explain/reassure others
Do not leave student alone
Record on Seizure Observation Record
other:______________________________________

○ *Atonic (Drop)*

Triggers	Length	Frequency

If you see this:

Sudden, brief loss of muscle tone

This seizure often causes injury

Head nods to total body drops	other:____

Do this:

Time the seizure. Usually only 1 - 2 sec	Explain/reassure others
Protect airway	Do not leave student alone
Treat injury	Record on Seizure Observation Record
	other:____

	Triggers	Length	Frequency
○ ***Myoclonic***			

If you see this:

Rapid, brief body jerk	Affects certain muscle groups, or one or both sides of the body
May occur singly or in clusters	other:____

Do this:	Speak softly/reassure/reorient	Record on Seizure Observation Record
Time the seizure	Do not leave student alone	Explain/reassure others
DO NOT restrain	Treat injury	other:____

EXPECTED BEHAVIOR AFTER SEIZURE - Return to baseline time is approximately 30 minutes

Behavior: *Regular breathing, sleepiness, weakness, nausea, confusion.* ***Instructions:*** *Reorient student. Allow student to rest/sleep. Stay with and monitor student. Do not give anything to eat or drink. Record on Seizure Observation Record.*

SIGNATURES/RELEASE OF INFORMATION - As Parent/Guardian of the named student:

* I give permission for my child's Health Care Provider to release/share information with the District Nurse for the completion of this plan of care and to exchange health information and records.

* I understand the information contained in this plan will be shared with school staff on a need-to-know basis.

* I give permission to the District Nurse and other designated staff to follow this Emergency Care Plan and administer medication as directed.

* I agree to release, indemnify, and hold harmless the District Nurse and other designated staff from lawsuits, claim expense, demand or action, etc., against them for helping my child with allergy treatment, provided the personnel are following physician instruction as written in the emergency action plan above.

* I understand I am responsible for maintaining necessary supplies, medication, and equipment.

* My child and I understand there are serious consequences for sharing any medication with others.

* I understand I am responsible to notify the District Nurse of any change in my child's health status, care, or medication order. If the prescription on the medication order is changed, I understand a new Medication Request Form and Emergency Care Plan Form must be completed before the school staff can administer the medication.

* I understand that if any emergency medication is administered at school, EMS will be notified for evaluation, monitoring, and possible further treatment.

* I understand that if my child is given emergency medication, he/she may not remain at school unless I can be present to monitor him/her for adverse reactions. I understand that trained school employee volunteers can only monitor him/her until I arrive or EMS arrive. I understand that if I want my child to remain in school after receiving emergency medication, I will have to stay with him/her at school.

Parent/Guardian Name (print):	**Phone:**
Parent/Guardian Signature:	**Date:**

HEALTHCARE PROVIDER - ***This student is under my care. This Seizure Action Plan reflects my plan of care.***

Healthcare Provider Name (print):	**Phone:**
Healthcare Provider Signature:	**Date:**
District Nurse:	**Date:**

Madison School District 321 Seizure Emergency Medication/Management Form	**School Year**	**Student Picture**
	School:	
	Grade:	

STUDENT INFORMATION

Student:		**DOB:**
Parent:	**Phone:**	**Email:**
Parent:	**Phone:**	**Email:**
Healthcare Provider:	**Phone:**	**Fax:**
District Nurse: Rachel Moore, RN	**Phone: 208-206-0908**	**Fax: 208-359-3370**

EMERGENCY SEIZURE RESCUE MEDICATION - A Medication Request Form is required for each medication

In addition to this Medication/Management Form, a Seizure Action Plan must be developed and signed by the Parent/Guardian, Physician, and District Nurse.

If Emergency Medication is administered:

* ALWAYS call 911, Parent, and District Nurse if medication is administered! Document on Seizure Observation Record.

* If a student is given emergency medication, he/she may not remain at school unless the parent/guardian can be present to monitor him/her for adverse reactions. Trained school employee volunteers can only monitor the student until the parent/guardian or EMS arrive. If the parent/guardian wants the student to remain in school after receiving emergency medication, the parent/guardian will have to stay with him/her at school.

Medication:	**Dose:**	**Route:**

Administer Emergency Medication If:

○ If seizure lasts __________ minutes or greater.

○ If _________ or more consecutive seizures occur with or without a period of consciousness in _________ minutes.

○ other ____

Common potential side effects:

Respiratory depression, memory loss, drowsiness, other____

Medication:	**Dose:**	**Route:**

Administer Emergency Medication If:

○ If seizure lasts __________ minutes or greater.

○ If _________ or more consecutive seizures occur with or without a period of consciousness in _________ minutes.

○ other ____

Common potential side effects:

Respiratory depression, memory loss, drowsiness, other____

VAGUS NERVE STIMULATOR

○ This student has a Vagus Nerve Stimulator (VNS). Location on body:____

Swipe magnet once if:

____

* Do not hover the magnet over the location of the VNS on the student's body. This could turn the mechanism off.

SIGNATURES/RELEASE OF INFORMATION

As Parent/Guardian of the named student:

* I give permission for my child's Health Care Provider to release/share information with the District Nurse for the completion of this plan of care and to exchange health information and records.

* I understand the information contained in this plan will be shared with school staff on a need-to-know basis.

* I give permission to the District Nurse and other designated staff to follow this Emergency Care Plan and administer medication as directed.

* I agree to release, indemnify, and hold harmless the District Nurse and other designated staff from lawsuits, claim expense,

demand or action, etc., against them for helping my child with allergy treatment, provided the personnel are following physician instruction as written in the emergency action plan above.

* I understand I am responsible for maintaining necessary supplies, medication, and equipment.

* My child and I understand there are serious consequences for sharing any medication with others.

* I understand I am responsible to notify the District Nurse of any change in my child's health status, care, or medication order. If the prescription on the medication order is changed, I understand a new Medication Request Form and Emergency Care Plan Form must be completed before the school staff can administer the medication.

* I understand that if any emergency medication is administered at school, EMS will be notified for evaluation, monitoring, and possible further treatment.

* I understand that if my child is given emergency medication, he/she may not remain at school unless I can be present to monitor him/her for adverse reactions. I understand that trained school employee volunteers can only monitor him/her until I arrive or EMS arrive. I understand that if I want my child to remain in school after receiving emergency medication, I will have to stay with him/her at school.

Parent/Guardian Name (print):	**Phone:**
Signature:	**Date:**
HEALTHCARE PROVIDER TO COMPLETE - please read, check one of the options, and sign below	
○ It is **medically appropriate** for the student to **self-carry and be in possession of emergency seizure medication** at all times.	
○ It is **NOT medically appropriate** for the student to **self-carry emergency seizure medication.** Please have the designated school personnel maintain and administer this student's medication in an emergency.	
This student is under my care. This Seizure Action Plan reflects my plan of care.	
Physician Name (print):	**Phone:**
Physician Signature:	**Date:**
District Nurse:	**Date:**

Student Name ____