Return To School Nurse

EMERGENCY ACTION PLAN

SEIZURE

Student Name: _____ DOB: _____ Grade/Teacher: _____

EMERGENCY CONTACT INFORMATION

Parents/Guardians:	Phone #1:	Phone #2:	Phone #3:
Alternate Contact:	Phone #1	Phone #2:	Phone #3:

Seizure Information

Seizure Type: _____ Normal Length/Frequency: _____
Seizure Triggers or Warning Signs: _____
Daily medication for seizures: _____
Does student have a Vagal Nerve Stimulator (VNS)? □ YES □ NO
Does student have an Emergency/Rescue Medication?□ YES □ NO Name?_____
*Emergency medication to be given for seizures lasting longer than _____ Minutes
*Emergency medication is stored? _____

IF YOU SEE THIS:	DO THIS:
Petit Mal and Psychomotor Seizure **Petit Mal (Absence Seizures) - Staring Spells. May drop an object s(he) is holding or may stumble momentarily. Usually last 2-5 minutes.** **Psychomotor- Some degree of impairment of consciousness may or may not be accompanied by automatic movements like lip smacking, roaming, and non-goal oriented activity. May last several seconds or minutes.**	***Notify the parent. No first aid is needed if no injury.** ***Record and report to nurse and parent.**
Grand Mal/Tonic-Clonic Seizure **Muscles tense, body rigid, followed by a temporary loss of consciousness and violent shaking of entire body.** ***Usually last 2-5 minutes** ***Emergency Medication? Yes / No** *To be administered for seizures lasting longer than _____ minutes.*	***Keep Calm, note the time when the seizure began** ***Call Code Blue and remove other students from area.** ***Do not restrain the student** ***Clear area around student so that student doesn't injure self.** ***Do not put anything in the mouth.** ***Loosen the student's clothing and remove eyeglasses or any sharp objects or nearby furniture.** ***If vomiting or choking, turn body to the side** ***If loss of bowel/bladder control, please cover student with blanket or jacket for privacy.** ***Do NOT give anything by mouth including medication until seizure is over and fully awake.** ***When seizure is over, have student to rest in a comfortable position.** ***Notify parents of seizure.** ***Record observations of seizure activity.**
IF YOU SEE THIS:	**IS:**

Please Sign on Back

Danger Signs:	***Call 911**
***Seizure lasts longer than 5 Minutes** ***No history of previous seizure.** ***Another seizure starts immediately after the first seizure.** ***Consciousness does not return at the end of a seizure.** ***Bluish color to lips AFTER seizure ends.** ***Stops breathing** ***If student is a diabetic, pregnant, or has a head injury or high fever.**	***Begin CPR and Rescue Breathing if breathing stops** ***Call Parents**

Symptoms to Expect After a Seizure *can last a few minutes or hours*

(Tiredness, weakness, sleepy, difficult to arouse, somewhat confused, regular breathing)

*These are all **NORMAL** post seizure*

I understand and agree that information in this Emergency Action Plan will be shared with appropriate school staff.

_____ _____

Parent/Guardian Signature Date

School Nurse Received and Reviewed: _____ _____

School Nurse Signature Date

To Be Completed By School Nurse

*Location of medicine*_____ *Authorized person to give medicine*_____

QUESTIONNAIRE FOR PARENT OF A STUDENT WITH SEIZURES

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

CONTACT INFORMATION:

Student's Name:_____ School Year:_____ Date of Birth:_____

School:_____ Grade:_____ Classroom:_____

Parent/Guardian Name:_____ Tel. (H):_____ (W):_____ (C):_____

Other Emergency Contact:_____ Tel. (H):_____ (W):_____ (C):_____

Child's Neurologist:_____ Tel:_____ Location:_____

Child's Primary Care Dr.:_____ Tel:_____ Location:_____

Significant medical history or conditions:

SEIZURE INFORMATION:

1. When was your child diagnosed with seizures or epilepsy?_____
2. Seizure type(s):

Seizure Type	*Length*	*Frequency*	*Description*

3. What might trigger a seizure in your child?_____
4. Are there any warnings and/or behavior changes before the seizure occurs? YES NO
   If YES, please explain:_____
5. When was your child's last seizure?_____
6. Has there been any recent change in your child's seizure patterns? YES NO
   If YES, please explain:_____
7. How does your child react after a seizure is over?_____
8. How do other illnesses affect your child's seizure control?_____

BASIC FIRST AID: Care and Comfort Measures

9. What basic first aid procedures should be taken when your child has a seizure in school?_____
   _____
   _____
   _____
   _____

Basic Seizure First Aid:
- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

10. Will your child need to leave the classroom after a seizure? YES NO
    If YES, What process would you recommend for returning your child to classroom:_____
    _____

SEIZURE EMERGENCIES

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)_____

_____

_____

_____

_____

12. Has child ever been hospitalized for continuous seizures? YES NO
    If YES, please explain: _____

_____

A Seizure is generally considered an Emergency when:

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or diabetic
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

SEIZURE MEDICATION AND TREATMENT INFORMATION

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and time of day taken	Possible side effects

14. What emergency/rescue medications needed medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to do after administration:

* *After 2nd or 3rd seizure, for cluster of seizure, etc.* ** *Orally, under tongue, rectally, etc.*

15. What medication(s) will your child need to take during school hours?_____
16. Should any of these medications be administered in a special way? YES NO
    If YES, please explain:_____
17. Should any particular reaction be watched for? YES NO
    If YES, please explain:_____
18. What should be done when your child misses a dose?_____
19. Should the school have backup medication available to give your child for missed dose? YES NO
20. Do you wish to be called before backup medication is given for a missed dose?
21. Does your child have a Vagus Nerve Stimulator? YES NO
    If YES, please describe instructions for appropriate magnet use:_____

_____

SPECIAL CONSIDERATIONS & PRECAUTIONS

22. Check all that apply and describe any considerations or precautions that should be taken

- ❑ General health_____
- ❑ Physical functioning_____
- ❑ Learning:_____
- ❑ Behavior:_____
- ❑ Mood/coping:_____
- ❑ Physical education (gym)/sports:_____
- ❑ Recess:_____
- ❑ Field trips:_____
- ❑ Bus transportation:_____

Other:_____

GENERAL COMMUNICATION ISSUES

23. What is the best way for us to communicate with you about your child's seizure(s)?_____

_____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent/Guardian Signature:_____ Date:_____ Dates Updated:_____, _____