**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
* 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)**
 |
| **TREATMENT/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\*\*\*Medications will be administered by the registered nurse, parent, or PDA |
| **LHP Signature** | **Date** | **Telephone****Fax Number** |
| **LHP Printed Name** | **Start Date** | **End Date** |

**EMERGENCY CONTACTS**

|  |
| --- |
| Name: |
| Primary # |
| Other # |
| Other # |



|  |
| --- |
| 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 employees to 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. \*\****

**SEIZURE OBSERVATION LOG**

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| --- |
| **Student Name** |
| **Date / Time** |  |  |  |
| **Seizure Length** |  |  |  |
| **Pre-Seizure Observation (briefly list behaviors, triggering events, activities)** |  |  |  |
| **Conscious (yes/no/altered)** |  |  |  |
| **Injuries (briefly describe)** |  |  |  |
| **Muscle tone/body movements** | Rigid/clenching |  |  |  |
| Limp |  |  |  |
| Fell down |  |  |  |
| Rocking |  |  |  |
| Wandering around |  |  |  |
| Whole body jerking |  |  |  |
| **Extremity movements** | (R) arm jerking |  |  |  |
| (L) arm jerking |  |  |  |
| (R) leg jerking |  |  |  |
| (L) leg jerking |  |  |  |
| Random movement |  |  |  |
| **Color** | Bluish |  |  |  |
| Pale |  |  |  |
| Flushed |  |  |  |
| **Eyes** | Pupils dilated |  |  |  |
| Turned (R or L) |  |  |  |
| Rolled up |  |  |  |
| Staring or blinking (clarify) |  |  |  |
| Closed |  |  |  |
| **Mouth** | Salivating |  |  |  |
| Chewing |  |  |  |
| Lip smacking |  |  |  |
| **Verbal Sounds (gagging, talking, throat clearing, etc.)** |  |  |  |
| **Breathing (normal, labored, stopped, noisy, etc.)** |  |  |  |
| **Incontinent (urine or feces)** |  |  |  |
| **Post-seizure observation** | Confused |  |  |  |
| Sleepy/tired |  |  |  |
| Headache |  |  |  |
| Speech slurring |  |  |  |
| Other |  |  |  |
| **Length of time to orientation** |  |  |  |
| **Parent/guardian notified (time of call)** |  |  |  |
| **9-1-1 called (call time & arrival time)** |  |  |  |
| **Staff member observing seizure (name)** |  |  |  |