**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**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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)** | |  |  |  |