Spencer County Public Schools Health Services

SEIZURE ACTION CARE PLAN

Must be completed by a **Licensed Health Professional**

PRINT Student Name: ______________________ School Year______________
Date of Birth: ______________________ Teacher/Grade______________
Date of Diagnosis: ______________________ Bus Route ______________

Emergency Contacts:

Name: ______________________ Numbers: ______________________
Name: ______________________ Numbers: ______________________
Name: ______________________ Numbers: ______________________

PRINT Treating Physician Name: ______________________ Number: ______________
Physician Address: ______________________ FAX # ______________

SEIZURE INFORMATION:

Date of Last Known Seizure	*Seizure Type*	*Description* (length/frequency/details)

Seizure triggers or warning signs: ______________________

Student's reaction to seizure: ______________________

Current medications: ______________________

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as: ______________________

____

Seizure Emergency Protocol: (**Check** all that apply and clarify below)

- ☐ Contact school nurse at: ______________________
- ☐ Administer emergency medications as indicated below
- ☐ Notify parent or emergency contact
- ☐ Notify Doctor
- ☐ Other ______________________

Comments______________________

*** Call 911 for transport if:**

- ☐ Respiratory distress;
- ☐ Seizure lasting **longer than** ____minutes;
- ☐ Student has repetitive seizures;
- ☐ **If Diastat is given it is recommended that student is either transported via ambulance to hospital or released to parents for close monitoring.**

Basic Seizure First Aid:

- Stay calm and 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

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 has diabetes
- Student has breathing difficulties
- Student has a seizure in water

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include emergency AND daily medications)

Will student require Emergency Medication or other prescribed Seizure Medication at School? ☐ YES ☐ NO

If YES, Parent and physician must complete a **Permission for Prescribed or Over-the-Counter Medication Form** for each medication needed at school.

Medications	*Dose*	*Side Effects & Instructions*
DIASTAT: ☐Yes ☐ No	Administer ____ mg of RECTAL DIASTAT AFTER ____ minutes of Seizure Activity	
Other Meds Required at School:		

This medication can be kept: ☐ On Student ☐ Office/Health Room ☐ Classroom

This medication is required to be available on the bus: ☐ YES ☐ NO

! *Back of Form Must Be Filled Out and Signed* !

PRINT STUDENT NAME ______________________________________

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Does Student have a **Vagus Nerve Stimulator (VNS)?** ☐ **YES** ☐ **NO**

If YES, describe magnet use:

____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS:

(regarding school activities, sports, trips, transportation, etc.)

____

____

COMMENTS: ____

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PHYSICIAN/MEDICAL Signature _________________________________ Date ________________

PARENT Signature ____ Date ________________

STAFF/SCHOOL NURSE Signature ______________________________ Date________________