SEIZURE

Mamaroneck Union Free School District

EMERGENCY ACTION PLAN

Student's name: _____ DOB: _____ Grade/class: _____

School: ❒ Central ❒ Chatsworth ❒ Mamaroneck Avenue ❒ Murray ❒ Hommocks ❒ High School ❒ Other _____

PHOTO ID

Mother/Guardian: _____ (H) _____

(C): _____ (W) _____

Father/Guardian: _____ (H) _____

(C): _____ (W) _____

Emergency Contact: _____ (H) _____

(C): _____ (W) _____

Physician student sees for seizures: _____ Phone: _____

Primary Care physician: _____ Phone: _____

Check if student has orders for **Diastat** in school: ❒

Restrictions (if any): _____ ❒ Check here if no restrictions

Emergency Intervention:

IF YOU SEE THIS:

- May experience an aura (unusually sensation) or feeling immediately preceding seizure, such as:
  - Visual hallucination
  - Strange sound
  - Lack of smell, strange smell
  - Urgent need to get to safety

  Mild blackout

  Daydreaming
- Rhythmic jerking or stiffening of all or some of the extremities and face.
- Unresponsive during and for some time after the seizure episode.

DO THIS:

1. Call School Nurse.
2. Wear gloves. Use infection control precautions.
3. Do not place anything in student's mouth.
4. Place on their side to prevent choking.
5. If student is standing or sitting, gently lower to ground to avoid a fall.
6. If possible, place a cushion or blanket under student's head.
7. Do not hold or restrain student.
8. Clear area around student to prevent injury from sharp objects.
9. Do not give food, drink or medication (unless given by the nurse with doctor orders)
10. Observe all of the student's activity during the seizure and record on seizure chart.
11. Stay with student at all times or designate another adult to do so.

WHEN SEIZURE IS OVER:

- Monitor breathing.
- Determine their level of awareness.
- Check for injuries.
- Provide for transportation and accompany student to Health Office.
- Notify parent for immediate transport home.

CALL 911 IF:

- Student's breathing is compromised in any way.
- Seizure lasts longer than 5 minutes, or as indicated by physician orders.
- Nurse is unavailable.

Comments/Special Instructions: _____

Signature of parent/guardian: _____ Date: _____

Signature of Health Care Provider: _____ Date: _____

Health Care Provider phone number: _____

Parent signature gives permission to speak to child's physician/practitioner and school staff as needed.

PARENT- PLEASE COMPLETE THE OTHER SIDE OF FORM

MAMARONECK UNION FREE SCHOOL DISTRICT

PARENT SEIZURE INFORMATION FORM

Dear Parents/Guardians:

Please complete the information below and return it to the Health Office as soon as possible. If any changes occur during the school year, please notify the School Nurse.

Name of Student: _____ Grade: _____

General History:

- How old was your child when he/she experienced their first seizure? _____
- How did you know your child was having a seizure? What symptoms did they exhibit? _____

_____

- Date of most recent seizure: _____ Date last seen by doctor: _____
- How often does your child have seizures? _____
- Does he/she experience an aura? If yes, please explain. No: ___ Yes: _____
- Do you know why your child has seizures?

___ Epilepsy ___ Injury or trauma to the head ___ Infection ___ Brain tumor ___ High fevers ___ Stroke

___ Unknown ___ other: _____

- How do you know your child is having a seizure now? What symptoms do they exhibit? _____

_____

- How long do the seizures usually last? _____
- What happens to your child after he/she has a seizure? _____
- Has the doctor given a name to the type of seizure your child has? No: ___ Yes (Name): _____
- Are there any restrictions because of his/her diagnosis of seizures (i.e. driving, swimming, biking)? If yes, what are the restrictions? None: ___ Yes: _____
- Medications child takes at home for seizures:

Name	Dose	How often
_____	_____	_____
_____	_____	_____

Side effects of medication that your child experiences: _____

- Following a seizure have you ever had to:

___ Give Rectal Diastat? ___ Call 911 for transport to the hospital?

- Additional information/instructions: _____

Thank you for help in providing the best care for your student.

Signature of Parent/Guardian: _____ **Date:** _____

PLEASE COMPLETE THE OTHER SIDE OF FORM

4/2016