

NAME:		Birthdate:	School:		
Grade:	Preferred Hospital:	<input type="checkbox"/> Bus #	<input type="checkbox"/> Walk	<input type="checkbox"/> 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 PSYCHOMOTOR 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 or is first tonic clonic seizure.
 - 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**).

_____ has a Vagus Nerve Stimulator (VNS) implanted in their neck. You will see the VNS under the skin on their LEFT chest. It turns on and off at intervals of _____ minutes at this time. When they have a seizure, a magnet (located: _____) is to be "swiped" across the VNS in the students left chest area.
**** While the VNS is on, you may hear a change in their voice. This is nothing to worry about and is normal****

- TREATMENT/MEDICATION ORDERS: VNS Magnet Instructions**
- If child is having repetitive seizures, or a tonic clonic seizure, swipe the magnet across the VNS in the chest area counting "one- one thousand-one." The stimulation that is triggered lasts 60 seconds.
 - If the seizure is still going on after one minute, you may repeat. Usually the seizure is over after one or two swipes.
 - If the seizure is still going after 2 swipes of the magnet, call 911 and administer emergency rescue medication, **if ordered**:
 - _____ (medication) _____ mg _____ (route).
 - Daily seizure medication: _____ Dose _____ Time _____
 - Takes seizure medication at home Takes seizure medications at school

LHP Signature	Date:	Telephone: Fax Number:
LHP Printed Name	Start Date:	End Date:

Document seizure activity on Seizure Observation Log (attached)

EMERGENCY CONTACTS

Name:
Primary #:
Other #
Other #

Parent/Guardian

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 911 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

- | | |
|--|--|
| <ul style="list-style-type: none"> ◆ Tiredness ◆ Weakness ◆ Sleeping ◆ Difficult to arouse ◆ May be somewhat confused | <ul style="list-style-type: none"> ◆ 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. ****