Mercer Co. Schools
Seizure Health Care Plan

Student's Name: _____Date of Birth:_____ Grade: _____ School:_____

Transportation: □ Bus AM_____ PM_____ □ Car □ Driver Allergies: _____

School Sponsored Sports & Activities your child is involved in: _____

My child has the following type of seizures: (please check any/all that apply):

□ **Petit Mal** (Absence Seizures)	Staring, eye blinking, loss of awareness, usually very brief (10-20 sec.) period of cessation in motion, Brief loss of consciousness; "daydreaming" appearance, Occasional brief muscular twitches, May occur several times/day;
□ **Complex Partial Seizures**	Remains conscious and appears to be awake, but is not fully aware of what is going on; distorted sense of smell, hearing, sight; involuntary rhythmic movements (shuffling feet, smacking lips, arm swinging, etc.); Does not remember episode after it is finished;
□ **Grand Mal** (Generalized Tonic-Clonic)	Convulsions, stiffening, breathing may be shallow, lips or skin may have bluish color, unconsciousness, confusion, weariness or belligerence when seizure ends;

Date of Last Seizure _____ Triggers: _____ Student Response after Seizure:_____

Treatment Orders- To Be Completed by Physician

If a seizure occurs, activate the following:

1. Note the time the seizure begins & notify the school nurse

2. Ensure student's safety (move hazards, protect head, loosen tight clothing around neck, position student on side)

3. Administer Medication/Treatment if indicated below:

□ DIASTAT (Diazepam rectal gel) _____MG rectally for seizure lasting > ____ minutes and/or > ____ seizures in ____ hours
□ Clonazepam _____ mg per instructions: _____
□ VNS (Vagal Nerve Stimulator) Magnet: *If checked, directions for use:* _____
□ Nayzilam (midazolam) Intranasal Spray_____
□ Valtoco Nasal Spray _____
□ Other _____
□ NO EMERGENCY MEDICATION IS ORDERED; Additional Comments: _____

4. Call EMS (911) if:

- Seizure lasts longer than five (5) minutes
- The student has one seizure after another without waking up (after emergency treatment has been rendered)
- Seizure behavior is different from other episodes
- You are alarmed by the frequency or severity of the seizure(s)
- You are alarmed by the color or breathing of the person
- The student has been injured
- This is the student's first seizure
- The student is pregnant or has diabetes

5. Notify school personnel trained in CPR/First Aid to stay with student and initiate CPR if needed prior to EMS arrival.

6. Notify Parent/Guardian or Emergency Contact listed below

7. If child requires transportation via EMS, a parent/guardian will meet student at the hospital.

Provider Printed Name: _____Provider Signature: _____Date:_____

To Be Completed By Parent/Guardian

I give permission for _____ to receive the above medication(s) or treatment at school according to standard school policy and expressly hold harmless and waive any liability on behalf of the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such as the result of negligence or misconduct on behalf of the school or its employees. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the physician's orders to be followed. I also give permission for this plan to be available for use in my child's school and for the nurse to contact the physician when necessary to carry out this plan.

Signature of Parent/Guardian: _____ Date: _____

Phone Number(s) of Parent/Guardian: Cell_____ Work_____ Home_____

Other Emergency Contact Name:_____Phone:_____

Staff Use Only: □ IC □ Teachers □ Bus □ Sports/Activities