SEIZURE ACTION PLAN

For School, School Sponsored Events, Home, and the Emergency Room

For the Neurologist - Please complete the following sections before distributing to patients/caregivers.

➢ *Emergency Seizure Plan and Treatment Order*

Purpose	How to Use
• Organizes critical information so that patients and their caregivers can be prepared and confident should an emergency seizure occur.	• To be completed by the physician. The form is retained by the patient/caregiver for appropriate dissemination to school personnel: nurses, teachers, and coaches.

➢ *Seizure Type Notification*

Purpose	How to Use
• Provides appropriate school personnel with a history of the student's seizure type(s).	• To be completed by the neurologist. The form is copied and distributed with Emergency Seizure Plan and Treatment Order.

➢ *"VNS and Routine" Seizure Treatment Protocols*

Purpose	How to Use
• Provides appropriate school personnel with specific instructions to use a Vagal Nerve Stimulator (VNS) magnet for seizures and special considerations and safety precautions for school activities, sports and trips.	• To be completed by the neurologist. The form is copied and distributed with Emergency Seizure Plan and Treatment Order.

For the School Nurse - These forms are provided to help manage the student's care.

➢ *Student Interview Form*

Purpose	How to Use
• Helps the school nurse better understand the student's knowledge of his or her epilepsy and provides valuable information on managing his or her seizures and health throughout the year.	• To be completed by the school nurse after interviewing the student. • Completed form does **not** need to be returned to the Neurology Clinic.

➢ *Seizure Record*

Purpose	How to Use
• Helps appropriate school personnel keep track of seizures as they occur and record them.	• After being completed, a copy should be sent home for parents' and /or caregivers' records.

For the Parent - These forms are provided to help you communicate important seizure related health information to your child's school and during any Emergency Room (ER) visit.

➢ *Seizure Information Notification Sheet*

Purpose	How to Use
• Provides appropriate school personnel with a history of the student's seizures and emergency contact information.	• Should be completed, copied, and distributed with Emergency Seizure Plan and Treatment Order. Take a copy to all ER visits.

PATIENT I.D.

CHOC Children's

Children's Hospital of Orange County
1201 West La Veta
Orange, CA 92868-3874

SEIZURE ACTION PLAN
For School, School Sponsored Events, Home, and the Emergency Room

To Be Completed By Neurologist

➢➢ Emergency Seizure Plan and Treatment Order ➣➣

Student Name: _____ DOB: _____

Treatment Order Date: _____ Weight: _____ Current As of Date: _____

Allergies: _____

Significant Medical Hx: _____

_____

_____

_____

Contact Information:

Parent/Guardian: _____ Phone: _____ Cell: _____

Parent/Guardian: _____ Phone: _____ Cell: _____

Printed Name of Treating Neurologist: _____

Treating Neurologist's - Phone: 714-509-7601 Fax: 855-246-2329

Emergency Response and Treatment Protocol

1. **Seizure Emergency Response Criteria:**

A. A "Seizure Emergency" is defined as (**please check all that apply**):

- ☐ A seizure (seizure type: _____) lasting > 5 minutes.
- ☐ A seizure (seizure type: _____) lasting > _____ minutes.
- ☐ A cluster of > _____ seizures (seizure type: _____) occurring in a 1 (one) hour time period.
- ☐ Other _____

B. Select appropriate response for "Seizure Emergency" (**please check all that apply**):

- ☐ NO "Diastat® Protocol" - Call 911 for "Seizure Emergency" as defined above.
- ☐ Go to Step 2 – Emergency Treatment Protocol – "Diastat® Protocol".
- ☐ Other _____

Neurologist Signature: _____ Date: _____ Time: _____

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To Be Completed By Neurologist

➢➢ Emergency Seizure Plan and Treatment Order ≺≺

Emergency Response and Treatment Protocol

2. **Emergency Treatment Protocol** - "Diastat® Protocol":

Use Diastat® AcuDial™ (diazepam rectal gel) for seizures

☐ YES - Indicated – See Below ☐ NO - Not indicated/Does not have – **Call 911**

☐ Diastat® _____ mg Rectal Gel:
Give _____ mg per rectum for seizure type: (_____) if seizure >_____ minutes, or if seizure clusters > _____ in 1 (one) hour.

✓ **Minimum** amount of time between Diastat® doses is 4 hours.

✓ **Maximum** number of doses per day/24 hours is: _____doses.

✓ **Call 911 if:**

- **Seizure does NOT STOP within _____ minutes of using Diastat®.**
- Seizure behavior is different from other typical "baseline" episodes.
- You are alarmed by the frequency or severity of the seizure.
- You are alarmed by the breathing pattern or color changes to lip, face or other areas.

After Diastat® given and/or if 911 called:

- ➢ Keep child on left side in "recovery position"
- ➢ Monitor for changes in breathing pattern or color changes to lips, face or other areas
- ➢ Protect head and keep airway open
- ➢ Keep child safe until help arrives
- ➢ Child may vomit, have a bowel movement (stool), or urinate during or after a prolonged seizure
- ➢ Do not put anything inside of mouth
- ➢ Do not restrain or hold down

Diastat® Side Effects: ***Drowsy, sleepy, unsteady, sedated, fatigued, poor coordination, behavior changes.***

Unlicensed personnel:

✓ Call 911 at all times when administering emergency anti-seizure medications. Per California Education Code 49474.7, calling 911 shall **not** require a child to be transported to an emergency room.

✓ Call School Nurse.

Licensed personnel:

✓ Parents/caregiver should be notified immediately.

✓ Parents/caregiver should receive a note/copy of the "Seizure Record" sent home with child.

✓ If Diastat® given, recommend child go home with parent/caregiver due to direct observation requirements. Child to be observed by an adult for 4 hours after Diastat® given.

Neurologist Signature: _____ Date: _____ Time: _____

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SEIZURE ACTION PLAN
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To Be Completed By Neurologist

➢➢ Emergency Seizure Plan and Treatment Order ➣➣

Seizure Type Notification

3. **Diagnosed Seizure Type**

Type of seizure (s)	Description*	
☐ Absence	• Staring • Eye blinking	• Loss of awareness • Other _____
☐ Atonic (Drop Attack)	• Loss of muscle control • Head may drop • Limp	• Unresponsive • May fall to the ground • Other _____
☐ Complex Partial	• Confused • Not fully responsive/unresponsive • May appear fearful	• Purposeless, repetitive movements • Other _____
☐ Generalized Tonic Clonic	• Convulsions • Stiffening • Breathing may be shallow • Lips or skin may have a bluish color	• Unconsciousness • Confusion, weariness, or belligerence when seizure ends • Other _____
☐ Myoclonic	• Sudden jerks of head, arms, legs • May occur several times in a row or "cluster"	• May be strong enough to fall to the ground • Other _____
☐ Simple Partial	• Remains conscious • Distorted sense of smell, hearing, sight	• Involuntary rhythmic jerking/twitching on one side • Other _____
☐ Tonic	• Sudden stiffening of body • May be rigid	• Arms and legs may extend outward • Other _____
☐ Spasms	• Sudden flexion or extension movements of arms and/or legs • Mostly proximal and include truncal muscles • Mimics a "startle response" seen in infants	• Typically occur several times in a row in a quick pattern and "cluster" • Other _____

- ***Student may experience some or all of the listed symptoms during a specific seizure.***
- Parent or school staff to use the information marked above to fill out the ***"Seizure Record"*** and bring it to the next neurology appointment. Review the "How to Use" section of the ***"Seizure Record"*** for directions.

Neurologist Signature: _____ Date: _____ Time: _____

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SEIZURE ACTION PLAN
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To Be Completed By Neurologist

➢➢ "VNS and Routine" Seizure Treatment Protocol ➣➣

"VNS" Seizure Treatment Protocol

1. **VNS (vagal nerve stimulator) Magnet Protocol for seizures**:

☐ YES - Indicated – See Below ☐ NO - Not indicated/Does not have

☐ Swipe magnet at onset of seizure
Location of VNS:
- ☐ Left upper quadrant of chest
- ☐ Other: _____

VNS Side Effects: Cough, tickle in throat, temporary hoarseness or voice change.

☐	**Standard Protocol:**	If seizure continues after 1 (one) minute of first swipe, may repeat 1 (one) swipe of magnet every minute for up to 3 (three) additional swipes.
☐	**Individualized Protocol:**	If seizure continues after_____minute(s) of first swipe, may repeat _____ swipe(s) of magnet every minute for up to _____additional swipes.

☐ If seizure does NOT STOP with VNS magnet swipe within 5 (five) minutes, use "Diastat® Protocol" – Step 2 of Emergency Treatment Protocol. **If no "Diastat® Protocol", call 911.**

After VNS used:

✓ Child may stay in class if back to baseline neurological status.

✓ Parents/caregiver should receive a note/copy of the seizure record sent home with child.

☐ If child is tired, fatigued, or any other concerns, child may rest in school office for a time frame of _____ minutes.

"Routine" Treatment Protocol

1. **Special Considerations & Safety Precautions:** (school activities, sports, trips, etc.)

☐ None	☐ No swimming
☐ No contact sports	☐ Swimming with 1:1 adult supervision
☐ No use of power tools/power equipment	☐ Wear "seizure" helmet at all times
☐ No activities or climbing above height of head	☐ Other:

Neurologist Signature: _____ Date: _____ Time: _____

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SEIZURE ACTION PLAN

For School, School Sponsored Events, Home, and the Emergency Room

Parent Consent for Management of Seizures at School

I (We), the parent/guardian of the named student below request that the following regimen for Management of Seizures in school be administered to our child in accordance with state laws and regulations.
I will:

1. **Provide the necessary supplies and equipment, including a 3 day emergency supply of medication.**
2. **Notify the school nurse if there is a change in student health status or change of physician.**
3. **Notify the school nurse immediately and provide new consent for any changes in doctor's orders.**
4. **Notify the school nurse if student has received emergency medication or anti-seizure medication in the last 24 hours.**

California Education Code Section, 49423 allows the school nurse or other designated non-medical personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.
I request that medication be administered to my child in accordance with our authorized health care provider's written instructions. I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified School Nurse. I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration and/or the prescribing authorized health care provider. I give my permission for the School Nurse to exchange verbal and written medication-related information with the authorized health care provider. The School Nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Authorized Health Care Provider Authorization for Management of Seizures at School

My signature below provides authorization for the above written order, including administration of Diastat®. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the School Nurse or other duly qualified supervisor of health. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

CHOC Children's Neurology Clinic
1120 West La Veta Avenue
Suite 125, Orange, CA 92868
Phone: (714) 509-7601 Fax: (855) 246-2329

Office Stamp

Printed Name of Neurologist: _____

Neurologist Signature: _____ Date: _____ Time: _____

School Nurse Signature: _____ Date: _____ Time: _____

PATIENT I.D.

SEIZURE ACTION PLAN
For School, School Sponsored Events, Home, and the Emergency Room

To Be Completed By School Nurse

➢➢ Student Interview Form ➣➣

Purpose: To help you establish a relationship with the student. This interview will also assist you in gathering additional medical information that will help manage his or her health throughout the year.
How to use: Set up ½ hour to meet with the student and use this form as a discussion guide.

Student's Name: _____ Age:_____Grade: _____

School: _____Teacher: _____ Classroom: _____

How old were you when your seizures began?_____

Do you have any special feelings before a seizure? ☐ Yes ☐ No ☐ Not Sure

If yes, please explain: _____

_____

What do you think happens during your seizures? _____

_____

_____

How do you feel after a seizure? _____

_____

_____

What medication(s) do you take? (You may need to ask the parent/caregiver for this information)

Medication	Dosing	Schedule

Who gives you your medications at home? _____
If medication is self-administered, then ask:
Do you remember to take your medication on your own? _____
Do you do anything special to remember to take your medication? _____

Questions continue on the next page of the Student Interview Form

SEIZURE ACTION PLAN
For School, School Sponsored Events, Home, and the Emergency Room

To Be Completed By School Nurse

➢➢ Student Interview Form ➣➣

What do you do if you miss a dose of medication? _____

_____

Do you feel any different if you miss a dose? _____

What things (if any) seem to bring on a seizure? (list) _____

_____

_____

How often do you have seizures? _____

Is there a time of day or situation when they occur most often? _____

_____

When was your last seizure? _____

Besides taking medication, how do you control your seizures? _____

_____

_____

What special problems (if any) do you have in school that you feel are related to your epilepsy? _____

_____

_____

Have you told any of your friends about your seizures? (If yes, what did you tell them, when, and how did they react?)

_____

_____

Have you told any of your teachers you have seizures? (If yes, what did you tell them, when, and how did they react? If no, advise student that teacher will be told. Encourage student to be included in the notification.)

_____

_____

If you have a seizure at school, what are your concerns and what can we do to help? (Suggested topics to discuss: How the School Nurse, Teachers, Coaches, and/or Classmates can help during a seizure.)

_____

_____

_____

_____

Additional Notes: _____

_____

_____

_____

School Nurse Signature: _____ Date: _____

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Seizure Record

Purpose: Helps appropriate school personnel and parents keep track of seizures as they occur and record them. This will help keep track of the frequency of each seizure type for the Neurologist.

How to Use:

- Write the current month, year and numerical date for each day on the calendar.
- Locate the marked **diagnosed seizure type(s)** on Section 3 of the *"**Emergency Seizure Plan and Treatment Order**"***.** Write each **diagnosed seizure type** in one the boxes below as "Seizure Type A, B, C, or D".
- Keep track of each seizure by making a "mark" next to the corresponding letter on the day the seizure happened. You can use a simple "mark" for each seizure. Examples: "I" = 1 (one seizure) or "II" = 2 (two seizures) or "III" = 3 (three seizures). Sign the form if you are keeping track of the seizure record.

Nurses: When completed, a copy should be sent home for parents' and /or caregivers' records.

Parents: Bring a copy with you to all Neurology appointments.

Month: ______________________	**Year:** ______________________
Seizure Type A: ______________________	Seizure Type C: ______________________
Seizure Type B: ______________________	Seizure Type D: ______________________

Sun	Mon	Tues	Wed	Thu	Fri	Sat
Date:						
A -	A -	A -	A -	A -	A -	A -
B -	B -	B -	B -	B -	B -	B -
C -	C -	C -	C -	C -	C -	C -
D -	D -	D -	D -	D -	D -	D -
A -	A -	A -	A -	A -	A -	A -
B -	B -	B -	B -	B -	B -	B -
C -	C -	C -	C -	C -	C -	C -
D -	D -	D -	D -	D -	D -	D -
A -	A -	A -	A -	A -	A -	A -
B -	B -	B -	B -	B -	B -	B -
C -	C -	C -	C -	C -	C -	C -
D -	D -	D -	D -	D -	D -	D -
A -	A -	A -	A -	A -	A -	A -
B -	B -	B -	B -	B -	B -	B -
C -	C -	C -	C -	C -	C -	C -
D -	D -	D -	D -	D -	D -	D -
A -	A -	A -	A -	A -	A -	A -
B -	B -	B -	B -	B -	B -	B -
C -	C -	C -	C -	C -	C -	C -
D -	D -	D -	D -	D -	D -	D -

Name of Recorder:______________________ Signature/Title:______________________

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SEIZURE ACTION PLAN

For School, School Sponsored Events, Home, and the Emergency Room

To Be Completed By Parent

➢➢Seizure Information Notification Sheet ➣➣

Purpose: To provide school personnel with a history of the student's seizure types and emergency contact information.

How to use: Should be completed, copied, and distributed with Emergency Seizure Plan and Treatment Order. Take a copy of all documents to each ER visit.

This student is being treated for epilepsy.
The information below should assist you if a seizure occurs during school hours.

Student's Name: _____ Date of Birth: _____

Parent to Complete

Emergency Contact Numbers

Parent/Caregiver name: _____ Phone: _____

Parent/Caregiver name: _____ Phone: _____

School Nurse: _____ Phone: _____

Student Seizure Information

Possible warning and/or behavior changes prior to the seizure _____

_____

Known seizure triggers _____

Average frequency of seizures (how many times per day or week) _____

Usual time of day seizure occurs _____

Average length of time seizures last _____

Other important information _____

Medication	Dosing	Schedule

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

This information was adapted from: "Questionnaire for Parents", "Seizure Information Sheet", and "Student Interview Form" from the Epilepsy Foundation – www.epilepsyfoundation.org and the "Seizure Preparedness Plan for Back to School" from Valeant Pharmaceuticals – www.diastat.com

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