ACADEMY OF THE HOLY NAMES

EMERGENCY CARE PLAN: SEIZURE DISORDER

To Be Completed By Parent

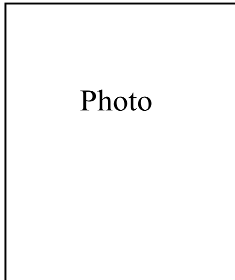
Student: ____________________________ Grade:_____ Teacher: _____________________ DOB: ____________

Mother's Name: ______________________ Home: _______________ Work: ______________ Cell: ______________

Father's Name:_______________________ Home: _______________ Work: ______________ Cell: ______________

Parent/Guardian Signature: ____ **Date:**____________________

This plan will be shared with district staff on a need to know basis to protect the safety of your child



SIGNS OF A GENERALIZED TONIC CLONIC SEIZURE MAY INCLUDE:

- Sudden loss of consciousness; bladder control may be lost
- Fall to the ground, sometimes with a cry
- Entire body usually becomes rigid, then jerking of the face, trunk and limb ensues
- Breathing may be shallow or may even stop
- When seizure activity stops, the child may be confused, drowsy or complain of headache

IN THE EVENT OF A SEIZURE, STAFF SHOULD:

- Notify nurse
- Clear the area of other students/objects if possible. Note time seizure started.
- Position student on side if possible. Do not restrain or put anything in the mouth.
- If possible, place something soft (blanket, towel) under head for protection. Remove glasses.
- If the seizure lasts **less than ____ minutes**, no other medical assistance is usually needed. Student may be tired.
- If there are multiple seizures or seizure lasts **longer than ____ minutes**, call 911.
- If breathing is shallow or stops, the child's lips or skin may have a bluish tinge, which corrects as the seizure ends.
- In the unlikely event that breathing does not begin again, check the child's airway for obstruction and begin CPR.

INSTRUCTIONS FOR THE BUS DRIVER:

- Pull over and stop bus. Lay student across a double or triple seat-facing away from seat, or in aisle.
- Follow plan above. Driver should notify dispatch per district procedures.
- Dispatch should notify school nurse at the number below if on the way to school.
- **If seizure last over ____ minutes**, ask dispatch to contact 911, then parent. Dispatch will also notify school nurse.

To Be Completed By Health Care Provider

Diagnosis (Type of Seizure)____

Medication (Dose/Route)____

*Rectal Medication can only be administered by an RN or LPN under the direction of an RN

☐ Medication administered by nurse at onset of seizure or within _______ minutes

☐ Medication must be available on bus: ☐ No ☐ Yes ☐ Medication is needed on field trips: ☐ No ☐ Yes

Use (VNS) Vagal nerve stimulator magnet ☐ NA ☐ Yes ____

Describe use and frequency

Activity Restrictions Needed ☐ No ☐ Yes (explain) ____

Doctor Name (Please Print): ______________________________Phone: _________________Fax: ________________

Doctor Signature: ____ Date: ___________________

This plan is in effect for the 201_ -201_ School Year

School Nurse: _____________________________________ **School** ____

Phone: ____________________________ **Fax:** ________________________ **Email** _________________________

Staff Members Instructed: ____