

School Year

20_____

ELIZABETHTON CITY SCHOOLS

SEIZURE ACTION PLAN

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To be completed by
Parent/Guardian/School Nurse
Please print

Child Information:

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____ Homeroom Teacher: _____

Emergency Information:

Date of Care Plan: _____

Parent/Guardian Names: _____

Mother's Phone #: Cell _____ Work: _____

Father's Phone #: Cell _____ Work: _____

In the event a Parent/Guardian cannot be reached, please list other adults that may be contacted in case of an emergency that may pick up your child and/or accompany your child to the Emergency Room if needed.

1. Name: _____ Relation: _____ Telephone: _____

2. Name: _____ Relation: _____ Telephone: _____

Student Medical Information:

Student's Primary Physician: _____ Office #: _____

Address: _____

ALLERGIES: ☐ NO ☐ YES (specify all): _____

TYPE OF SEIZURE (check all that apply): ☐ Primary Generalized Seizures (Absence, Myoclonic, Atonic, Tonic/Clonic) ☐ Partial Seizures (Simple, Complex) ☐ Other (please specify): _____

HOW OFTEN DO SEIZURES OCCUR (be specific): _____

DOES CHILD HAVE A RX FOR DIASTAT? ☐ YES ☐ NO **DIASTAT WILL BE KEPT AT SCHOOL** ☐ YES ☐ NO

ALL CURRENT MEDICATIONS USED FOR SEIZURES:

Name of Medication	Dosage and Strength	Time of Day Given

Triggers that may bring on a seizure (check all that apply):

☐ Fever ☐ Lack of Sleep ☐ Missed Medication Dosage ☐ Stress

☐ Photosensitivity Other (Please List): _____

I understand that it is my responsibility to keep this information current and to provide an updated form on at least an annual basis. I agree to maintain an adequate supply of medication at school. I give my permission for school personnel, who volunteer under no duress and are trained by a Registered Nurse, to participate in the care of my child in the event a school nurse is not present. I hereby agree and understand that the Elizabethton City School system and its personnel shall not be held liable for any injury resulting from the reasonable and prudent assistance in the administration of medication/treatment to my child. I give permission for the school nursing staff to share protected healthcare information with other school staff members on a need to know basis.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Staff Members Trained:

Name	Title	Location/Room	Trained By (RN only)

School Year

20_____

ELIZABETHTON CITY SCHOOLS

SEIZURE ACTION PLAN

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To be completed by
Physician
Please print

CHILD INFORMATION:

NAME: _____ DATE OF BIRTH: _____

Parent/Guardian Name: _____

Address: _____

ATTENDING PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

SEIZURE INFORMATION (To be filled out by HealthCare Provider):

SEIZURE TYPE	FREQUENCY	DESCRIPTION/COMMENT

TREATMENT PROTOCOL DURING SCHOOL HOURS (Include daily and emergency medications):

DAILY OR EMERGENCY MEDICATION	DOSAGE AND FREQUENCY	COMMON SIDE EFFECTS

IF **DIASTAT** IS ORDERED PLEASE CLARIFY:

GIVE DIASTAT _____ MG PER RECTUM FOR SEIZURES LASTING LONGER THAN _____ MINUTES.

CALL 911 IF THE SEIZURES DO NOT STOP _____ MINUTES AFTER EMERGENCY MEDICATION GIVEN OR IF CHILD HAS BREATHING PROBLEMS DURING OR AFTER SEIZURES.

DOES STUDENT HAVE A VAGUS NERVE STIMULATOR (VNS)? CHECK ONE ☐ YES ☐ NO

Basic Seizure First Aid:

- Stay calm
- Do not put anything in child's mouth
- Do not restrain child
- Keep child safe/ protect head
- Stay with child until fully conscious
- Record seizure/activity
- Roll onto side after jerking stops OR immediately if food/fluid/vomit is in the mouth

A Seizure is an Emergency When:

- A convulsive seizure last longer than 5 minute
- Student has repeated seizures without regaining consciousness
- 1st time seizure for student
- Student is injured or student is a diabetic
- Student has breathing difficulties
- Student has a seizure in water
- Student has food/fluid/vomit in mouth during seizure
- Another seizure follows quickly

HEALTHCARE PROVIDER SIGNATURE: _____ DATE: _____

I give permission for the Elizabethton City School nursing staff and my child's HealthCare provider to exchange protected healthcare information in order to clarify and/or maintain an Emergency Care Plan for my child.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

SCHOOL: _____ PHONE: _____

SCHOOL NURSE: _____ FAX: _____