

LOS ALAMITOS UNIFIED SCHOOL DISTRICT

Seizure Action Plan

Student Name: _____ DOB: _____

School: _____ Grade/Teacher: _____

Parent/Guardian: _____ Phone # _____

Printed Name of Treating Neurologist: _____

Treating Neurologist's Phone # _____ Fax# _____

Seizure type: _____ Length: _____ Frequency: _____

Seizure type: _____ Length: _____ Frequency: _____

Seizure Triggers or Warning signs: _____

Students reaction to seizure: _____

Significant Medical History: _____

Special Considerations (PE, recess, field trip): _____

Emergency Response and Treatment Protocol → Completed by Physician / Health Care Provider

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

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

Select Appropriate Response for a "Seizure Emergency" (please check all that apply)

- Call 911* for "Seizure Emergency" as defined above
- NO "Emergency Medication Protocol"

Emergency Medication such as: Nayzilam, (midazolam), Valtoco (diazepam nasal spray), Diastat (diazepam rectal gel)

"Emergency Medication Protocol"- as defined below:

Medication Name _____ Dose: _____ mg Route: _____ nasal, rectal, other: _____

Minimum amount of time between doses _____. Max # of doses per day _____

*Calling 911 does not necessitate transport to emergency department if parents are available to speak with emergency medical responders and make arrangement to pick-up child.

Other _____

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Student Name: _____ DOB: _____

Protocol For Observation At School After A Seizure (please check all that apply):

- Child should rest in Health Office for _____ minutes.
Child may return to class
Contact parent/guardian to pick-up child from school.

Basic Seizure First Aid Care:

- Stay calm and track time
Do not restrain
Do not put anything in mouth
Turn child on side
Provide privacy
Keep child safe and protect head
Stay with child until fully conscious
Loosen constrictive clothing, especially at neck and chest
Keep airway open and watch breathing and circulation
Record seizure on District seizure log

Special Considerations (PE, Recess, Field trip)

- None
No Contact Sports
No use of power tools/power equipment
No activities or climbing above height of head
Other: _____
No swimming
Swimming with 1:1 adult supervision is OK
Wear "seizure" helmet at all times

Parent/Guardian signature below indicates agreement to and understanding of the following:

- 1. Approval of the above guidelines and permission for info regarding child be available for school staff.
2. Completion of all authorization forms and providing medication orders from physician to administer medication.
3. Responsibility to inform the Health Office of any changes in child's health, treatment plan & provide new orders.
4. Provide the necessary supplies and equipment, including a 3 day emergency supply of medication.
5. Notify the Health Office if child received emergency medication or anti-seizure medication in the last 24 hours.

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 credentialed School Nurse.

Parent 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 by a credentialed School Nurse.

This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (May be faxed).

Printed Name of Neurologist _____

Neurologist Signature _____

Date _____ Phone# _____

5-23-22

