SEIZURE
Emergency Care Plan / 504

Student Photo

Student Name:		DOB:	
School:	School Year:		Grade:
Advisor	Transportation: ☐ Walker ☐ Car ☐ Bus Rider – Bus number:		

SEIZURE HISTORY
This section to be completed by parents/guardian

What **type of seizures** does your child have? Name of diagnosis: ______________________

When was the seizure disorder diagnosed? ______________________

When was the last time your child had a seizure? ______________________

Approximately how often does your child have a seizure? ______________________

Are your child's seizures life-threatening? Yes ☐ No ☐

Does your child have prescribed emergency medication? Yes ☐ No ☐

Does your child use electrical or vagus nerve stimulation therapy? Yes ☐ No ☐

TYPICAL SEIZURE PATTERN

Warning Signs: (feelings before seizure, conditions that cause/trigger seizures, behavior changes)

____

Usually Looks Like: (how long does seizure last, what part/s of body are involved, what does the child look like during the seizure, is breathing affected, when do they occur) ______________________

____

After It's Over: (what does the child feel like after a seizure) ______________________

EMERGENCY AND 72-HOUR MEDICATION ORDERS
Please refer to Seattle Children's and/or other Neurology orders

Medication: ______________________

Route: ☐ Intranasal ☐ Rectal

Dose: ______________________

Time: ______________________

Side effects: ______________________

In the absence of a school nurse, call 911 and notify paramedics of emergency medication order on file.

Daily Medications:

Daily medication required in the event of a major disaster at school. 72-hours of ______________ medication,
Time: ______________ Route: **Oral** Dose: ______________________

Healthcare Provider's Signature: ***see orders.***

EMERGENCY INTERVENTION	
Seizure Observed	**Immediate Response**
Tonic-Clonic (Grand Mal) **Absence seizures** (petit mal) **Focal Aware Seizures** (simple partial seizures) **Focal Impaired Awareness Seizures** (complex partial seizures)	• Follow Licensed Healthcare Provider order for when to call 911. Notify Parents. • Stay calm & document time seizure starts • Provide first aid if seizure becomes convulsive or student is injured • Keep child safe, Clear area, Protect head • Do not restrain the student • Turn on their side, do NOT put anything in mouth • Keep airway open/watch breathing • Stay with child until fully conscious • Document Seizure
Seizure is an Emergency When: • Any type of seizure activity lasting longer than 4 min. (or as ordered by the student's health care provider) • Repeated seizures without regaining consciousness • Student is injured • Student has diabetes, heart disease or pregnancy • Student has a first-time seizure • Student has breathing difficulties • Student has a seizure in water • Diastat or Midazolam has been administered	**CALL 911** **CALL PARENTS**

EMERGENCY CONTACTS		
Name	**Phone**	**Relationship**
1.		
2.		
3.		

PARENT/GUARDIAN CONSENT – You must complete and **SIGN**

☐ I request that authorized school personnel assist my child to take the medicine(s) described above. (if no box is checked, this option is the default.)

☐ I request that my child be permitted to self-administer the medicine(s) described above. I will hold harmless and indemnify the District, its officers, employees and personnel against all claims of liability arising out of the student's self-administration or carrying of medication.

☐ I am at least 18 years old and sign this form on my own behalf (RCW 26.28.015 or RCW 70.02.130).

☐ I consent to the evaluation and accommodation plan here provided, and have received a copy of Section 504 Parent/Student Rights.

My signature indicates my permission for the exchange of information between school staff and the health care provider, and my understanding that the District and school staff will not incur any liability for any injury when the medication is administered in accordance with the health care provider's direction and Washington law. I understand that if this is a plan for a life-threatening condition it can only be discontinued, in writing, by a healthcare provider.

The permission to possess and self-administer medication may be revoked by the school nurse if it is determined that your child is not safely and effectively possessing and self-administering medication.

It is strongly recommended that extra medication be provided and stored in the school heath room.

Parent Signature: **Date:**

School Nurse – Complete this section.

School Nurse: **Date:**

A copy of this plan is available in Skyward and will be kept in the school health room and copies will be given to:

☐ Teachers/Specialists ☐ Transportation ☐ Coach ☐ Other: