SEIZURE CARE PLAN AND MEDICATION ORDERS Plan ___ of ____

NAME:		Birthdate:	School:	
Grade:	Preferred Hospital:	☐ Bus #	☐ Walk ☐Drive	Weight
History (including current medication)				

TYPES of SEIZURES		
Tonic Clonic	**Absence**	**Psychomotor**
Muscles tense, body rigid, followed by a temporary loss of consciousness and violent shaking of entire body. **Comments**	Staring spells. May drop an object s(he) is holding or may stumble momentarily. **Comments**	Some degree of impairment of consciousness-- may have automatic movements like lip smacking, roaming, and non-goal oriented activity. **Comments**
*IDENTIFY students usual signs/symptoms	*IDENTIFY students usual signs/symptoms	*IDENTIFY students usual signs/symptoms

IF YOU SEE THIS	DO THIS Adult stays with student at all times
ABSENCE **AND** **PYSCHOMOTOR SEIZURES**	Time seizure and monitor student closely. Notify the nurse_____and parent/guardian_____. Gently support and protect student from harm. Do not restrain. No first aid is needed if no injury. After seizure, calmly re-orient student to their surroundings. After seizure, record seizure activity on Seizure Observation Log.
TONIC CLONIC **Do not hold student down** **Do not put anything in their mouth** (for loss of bowel/bladder, cover with blanket for privacy)	Time seizure activity. Stay calm & ease student to floor to avoid a fall. If trained, administer medication/treatments as ordered below. Clear area around student-move hard objects. Keep others away. Support student on their left side to allow vomit/drool to drain. Loosen clothing around neck. Place soft material under head. Notify the nurse_____ and parent/guardian_____. After seizure record events on the Seizure Observation Log.

CALL 911 IF:

- Seizure does not stop by itself or is 1st tonic clonic seizure
- Seizure does not stop within_____minutes
- Child does not start waking up within_____minutes after seizure is over
- Another seizure starts immediately after the first seizure
- Bluish color to lips AFTER seizure ends
- Prolonged loss of consciousness
- Stops breathing **(START RESCUE BREATHING/CPR)**

MEDICATION ORDERS

- For seizure lasting over _____minutes **OR** for_____or more _____(type) seizures in_____minutes/hours **OR**
- Child does not start waking up within_____minutes after seizure is over
- **If nurse available, administer** _____ (medication) _____mg _____ (route) for _____(type)

  for intra-nasal midazolam: give _____ml divided---1/2 dose (_____ml) into each nostril
- Call 911 when seizure emergency medication has been administered
- Daily seizure medication: _____ Dose: _____ Time: _____

  ☐ Takes seizure medication at home ☐ Takes seizure medication at school
- ☐ **NO MEDICATIONS HAVE BEEN ORDERED**

LHP Signature	Date	Telephone Fax Number
LHP Printed Name	Start Date	End Date

*****Document seizure activity on Seizure Observation Log (attached)*****

EMERGENCY CONTACTS

Name:
Primary #
Other #
Other #

Parent/Guardian

Name:
Primary #
Other #
Other #

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Accommodations needed _____ No _____ Yes If yes, list below:

- A new EAP and medication/treatment orders for seizures must be submitted each school year.
- If any changes are needed on the EAP, it is the parent/guardian's responsibility to contact the school nurse.
- It is the parent/guardian's responsibility to alert all other **non-school** programs of their child's health condition.
- Medical information may be shared with school staff working with my child and EMS staff, if they are called.
- I have reviewed the information on this Seizure Emergency Action Plan/504 and medication/treatment orders and request/authorize trained school employeesto provide this care and administer medication/treatments in accordance with the Licensed Healthcare Provider's (LHP's)instructions.
- This is a life-threatening plan and can only be discontinued by the LHP.
- I authorize the exchange of information about my child's seizure disorder between the LHP office and the school nurse.
- *My signature below shows I have reviewed and agree with this health care/504 plan and medication/treatment orders.*

Parent/Guardian Signature Date

EXPECTED POST-SEIZURE BEHAVIOR

- Tiredness
- Weakness
- Sleeping
- Difficult to arouse
- May be somewhat confused
- Regular breathing
- This period may last a few minutes or hours

For District Nurse's Use Only ☐ **504 Plan**

A registered nurse has completed a nursing assessment and developed this Seizure Care Plan in conjunction with this student, their parent/guardian and their LHP.

Medication/Device(s)	**Expiration date(s)**

School Nurse Signature **Date** **Phone**

Health care/504 plan and medication (if prescribed) must accompany student on any field trip or school activity.

***** Keep plan readily available for Substitutes. *****