SEIZURE

Emergency Care Plan

No Image Available

Student Name:		DOB:
School:	School Year	Grade:
Transportation ☐ Walker ☐ Car ☐ Bus Rider - Bus Number:		Advisor:

STUDENT SEIZURE OVERVIEW

Seizures Description (look like, length...)	

SEIZURE FIRST AID

STAY with them until they are awake and alert.
- Time the seizure
- Stay calm

Keep them **SAFE.**
- Move or guide them away from harm

Turn them onto their **SIDE** if they are not awake and aware.
- Keep airway clear
- Loosen tight clothing around neck
- Put something small and soft under the head

Provide first aid for injuries.
Do NOT restrain.
Do NOT put any objects in their mouth.

SEIZURE IS AN EMERGENCY WHEN:

Call 911 if:
- **Seizure lasts longer than ____ minutes**
- **Clusters of _ seizures per minutes**
- **Does not return to usual state**
- **Difficulty breathing**
- **Serious injury occurs or is suspected or seizure occurs in water**
- **Rescue medications have been administered**

Administer **RESCUE** medications if prescribed.

Use VNS if indicated..

Notify the parent
Document in seizure log

CARE AFTER SEIZURE

Description of type of help needed	
First Responders	
Emergency Department	

MEDICATION ORDERS

This section to be completed by a LICENSED HEALTHCARE PROVIDER (HCP) if prescribed

☐ **Yes** **This is a life-threatening condition for this student that requires medication and a care plan at school**
☐ **No** **PRIOR to attending school safely per RCW 28A.210.320.** If no box checked, default is not life threatening.

Medication	☐ Diastat ☐ Midazolam ☐ Lorazepam ☐ Other
Route	☐ Nasal ☐ Rectal (Only nurse may administer, Call 911 if no nurse) ☐ Oral
Dose	
Indications	☐ Administer for seizures lasting more than ____ minutes ☐ Administer for clusters of ____ seizures per ____ minutes ☐ Other:
Side Effects	

Medication orders and treatment plan expiration date: ☐ End of current school year ☐ Other:

Healthcare Provider's **Signature**:		☐ Signature on File	Date: _____
Healthcare Provider's Name:		HCP Phone:	HCP Fax:

Name:	**SEIZURE ECP**	Age:	Grad Year:

SEIZURE INFORMATION

Seizure type	Typical length of seizure	Frequency	What the seizures look like in my child:

Date of last seizure:

Daily Medications:	
Triggers	
Epilepsy Surgery (type, date, side effects)	

Diet Therapy	☐ Ketogenic	☐ Low Glycemic	☐ Modified Atkins	☐ Other (describe)
Seizure Device	☐ RNS Responsive Nerve Stimulation	☐ DBS Deep Brain Stimulation	Date Implanted	

☐ **VNS** Vagus Nerve Stimulator

1. Keep magnet within 10-15 feet of student so it's accessible to activate the VNS.	Magnet location _____
2. Try to activate VNS at seizure onset to maximize effect.	
3. Pass magnet over unit (left shoulder/axilla) for a minimum of 2 - 3 seconds. This initiates a dose of stimulation lasting 60 seconds.	Possible Side effects: voice change, cough, nausea, rapid heart rate
4. Can be repeated a total of 5 times. Wait 60 seconds between each magnet pass.	

Other Medical History	

SPECIAL INSTRUCTIONS

* Individual health plan and rescue medication, if prescribed, must accompany student on any field trip or scheduled activity.
* Keep health plan readily available for substitutes.
* Notify parent/guardian of any concerns.

☐ Other	

PARENT/GUARDIAN INFORMATION

Parent/Guardian:	Home Phone:	Work Phone:	Cell Phone:
Parent/Guardian:	Home Phone:	Work Phone:	Cell Phone:

EMERGENCY CONTACTS INFORMATION

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

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 is the default.)

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

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 health care provider.

By signing, I am indicating agreement with this plan.

Parent Signature:	☐ Parent/Guardian Signature on File	Date:

School Nurse and Administrator - Complete this section.

School Nurse:		☐ Nurse's Signature on File	Date:	
Administrator:		☐ Administrator's Signature on File	Date:	