

Seizure Care Plan and Medication Orders/504

Place
Photo
Here

Plan: _____ / _____ Date plan created: _____ Date plan revised: _____ Weight: _____ Height: _____	
NAME: _____	Birthdate: _____ PE/Sport: _____
Grade: _____	School: Cheney Public Schools ☐ Bus # ☐ Walk ☐ Drive
Doctor: _____	Phone: _____ Fax: _____ Preferred Hospital: _____

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.	Staring spells. May drop an object s(he) is holding or may stumble momentarily.	Some degree of impairment of consciousness-- may have automatic movements like lip smacking, roaming, and non-goal oriented activity.
Comments	Comments	Comments
**BOLD students usual signs/symptoms	**BOLD students usual signs/symptoms	**BOLD 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
- _____ (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		LHP Print Name	
Start date	End date ☐ Last day of school ☐ Other		
Date	Telephone	Fax	

Seizure Care Plan and Medication Orders – Part 2 – Parent/Guardian (STUDENT): _____

EMERGENCY CONTACTS

Parent/Guardian	Name	Parent/Guardian	Name
	Primary #		Primary #
	Other #		Other #
	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 employees to 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 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. ****