

**LIBERTY SCHOOL DISTRICT SEIZURE EMERGENCY ACTION PLAN--VERSED OR DIASTAT ☐ 504 Plan**

Date plan created: \_\_\_\_\_ Date plan revised: \_\_\_\_\_

|               |               |                                |                               |                                |
|---------------|---------------|--------------------------------|-------------------------------|--------------------------------|
| NAME: _____   |               | Birthdate: _____               | Teacher: _____                |                                |
| Grade: _____  | School: _____ | <input type="checkbox"/> Bus # | <input type="checkbox"/> Walk | <input type="checkbox"/> Drive |
| Doctor: _____ | Phone: _____  | Fax: _____                     | Preferred Hospital: _____     |                                |

History (including current medication): \_\_\_\_\_

| TYPES of SEIZURES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p align="center"><b>Tonic Clonic</b></p> <p>Muscles tense, body rigid, followed by a temporary loss of consciousness and violent shaking of entire body.</p> <p>Comments: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                        | <p align="center"><b>Absence</b></p> <p>Staring spells. May drop an object s(he) is holding or may stumble momentarily.</p> <p>Comments: _____</p>                                                                                                                                                                                                                                                                                    | <p align="center"><b>Psychomotor</b></p> <p>Some degree of impairment of consciousness, may or may not be accompanied by automatic movements like lip smacking, roaming, and non-goal oriented activity.</p> <p>Comments: _____</p> |
| <b>IF YOU SEE THIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>DO THIS</b><br>Adult stays with student at all times                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                     |
| <b>ABSENCE<br/>AND<br/>PYSCHOMOTOR SEIZURES:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Time seizure and monitor student closely.<br>Notify the nurse _____ and parent _____.<br>Gently support and protect student from harm. Do not restrain.<br>No first aid is needed if no injury.<br>After seizure, calmly reorient student to his surroundings.<br>Record seizure activity on Seizure Observation Log.                                                                                                                 |                                                                                                                                                                                                                                     |
| <b>TONIC CLONIC<br/>SEIZURE ACTIVITY</b><br><u><b>Do not hold student down. Do not put anything in their mouth.</b></u><br>(for loss of bowel/bladder cover with blanket for privacy)                                                                                                                                                                                                                                                                                                                                                                                                                                       | Time Seizure Activity. After seizure record events on the Seizure Observation Log.<br>Stay calm & ease student to floor to avoid a fall.<br>Administered medications as ordered below.<br>Clear area around student-move hard objects. Keep others away.<br>Support student on his left side to allow vomit/drool to drain.<br>Loosen clothing around neck. Place soft material under head.<br>NOTIFY THE NURSE _____ & PARENT _____. |                                                                                                                                                                                                                                     |
| <b>CALL 911 IF:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                     |
| <div style="display: flex; justify-content: space-between;"> <div> <ul style="list-style-type: none"> <li>Seizure does not stop by itself or is first tonic clonic seizure</li> <li>Seizure does not stop within _____ minutes</li> <li>Child does not start waking up within _____ minutes after seizure is over</li> </ul> </div> <div> <ul style="list-style-type: none"> <li>Another seizure starts immediately after the first seizure</li> <li>Bluish color to lips AFTER seizure ends</li> <li>Prolonged loss of consciousness</li> <li>Stops breathing (<b>START RESCUE BREATHING/CPR</b>)</li> </ul> </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                     |
| ➤ <b>VERSED</b> (Midazolam intra-nasal spray) _____ mg intra-nasal prn <i>OR</i> <b>DIASTAT</b> (rectal diazepam) _____ mg for:<br>Seizure > _____ minutes OR for _____ or more seizures in _____ hours<br>➤ Child does not start waking up within _____ minutes after seizure is over                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                     |
| <b>Document seizure activity on Seizure Observation Log (attached).</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                     |

|                  |             |             |
|------------------|-------------|-------------|
| LHP Signature    | Date        | Telephone:  |
|                  |             | Fax Number: |
| LHP Printed Name | Start Date: | End Date:   |

## PARENT/GUARDIAN SECTION

### EMERGENCY CONTACTS

|            |
|------------|
| Name       |
| Home Phone |
| Work Phone |
| Other      |

|            |
|------------|
| Name       |
| Home Phone |
| Work Phone |
| Other      |

### ADDITIONAL EMERGENCY CONTACTS:

|    |               |        |
|----|---------------|--------|
| 1. | Relationship: | Phone: |
| 2. | Relationship: | Phone: |

**\*\*Does the student need classroom, school activity, or recess accommodations? \_\_\_\_yes \_\_\_\_no. If yes, please specify \_\_\_\_**

- A new health care plan for seizures must be submitted each school year.
- I understand that if any changes are needed on the HCP, it is the parent's responsibility to contact the school nurse.
- It is the parent'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 your child and 911 staff, if they are called.
- I have reviewed the information on this health care plan and medication order and request/authorize trained school employees to provide this care and administer this medication in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- I understand 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 plan.*

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

### EXPECTED POST-SEIZURE BEHAVIOR

- |                                                                                                                                                                |                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>◆ Tiredness</li> <li>◆ Weakness</li> <li>◆ Sleeping, difficult to arouse</li> <li>◆ May be somewhat confused</li> </ul> | <ul style="list-style-type: none"> <li>◆ Regular breathing</li> <li>◆ Can last a few minutes or hours</li> <li>◆ May be somewhat confused</li> </ul> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|

#### For District Nurse's Use Only

This plan has been reviewed/approved by the School District Nurse.

Medication/Device(s)

Expiration date(s):

School Nurse Signature

Date

Phone:

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

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

## SEIZURE OBSERVATION LOG

|                                                                                 |                               |  |  |  |
|---------------------------------------------------------------------------------|-------------------------------|--|--|--|
| Date & Time                                                                     |                               |  |  |  |
| Seizure Length                                                                  |                               |  |  |  |
| Pre-Seizure Observation (Briefly list behaviors, triggering events, activities) |                               |  |  |  |
| Conscious (yes/no/altered)                                                      |                               |  |  |  |
| Injuries (briefly describe)                                                     |                               |  |  |  |
| Muscle tone/body movements                                                      | Rigid/clenching               |  |  |  |
|                                                                                 | Limp                          |  |  |  |
|                                                                                 | Fell down                     |  |  |  |
|                                                                                 | Rocking                       |  |  |  |
|                                                                                 | Wandering around              |  |  |  |
|                                                                                 | Whole body jerking            |  |  |  |
| Extremity movements                                                             | (R) arm jerking               |  |  |  |
|                                                                                 | (L) arm jerking               |  |  |  |
|                                                                                 | (R) leg jerking               |  |  |  |
|                                                                                 | (L) leg jerking               |  |  |  |
|                                                                                 | Random Movement               |  |  |  |
| Color                                                                           | Bluish                        |  |  |  |
|                                                                                 | Pale                          |  |  |  |
|                                                                                 | Flushed                       |  |  |  |
| Eyes                                                                            | Pupils dilated                |  |  |  |
|                                                                                 | Turned (R or L)               |  |  |  |
|                                                                                 | Rolled up                     |  |  |  |
|                                                                                 | Staring or blinking (clarify) |  |  |  |
|                                                                                 | Closed                        |  |  |  |
| Mouth                                                                           | Salivating                    |  |  |  |
|                                                                                 | Chewing                       |  |  |  |
|                                                                                 | Lip smacking                  |  |  |  |
| Verbal Sounds (gagging, talking, throat clearing, etc.)                         |                               |  |  |  |
| Breathing (normal, labored, stopped, noisy, etc.)                               |                               |  |  |  |
| Incontinent (urine or feces)                                                    |                               |  |  |  |
| Post-seizure observation                                                        | Confused                      |  |  |  |
|                                                                                 | Sleepy/tired                  |  |  |  |
|                                                                                 | Headache                      |  |  |  |
|                                                                                 | Speech slurring               |  |  |  |
|                                                                                 | Other                         |  |  |  |
| Length to Orientation                                                           |                               |  |  |  |
| Parents Notified? (time of call)                                                |                               |  |  |  |
| 9-1-1 Called? (call time & arrival time)                                        |                               |  |  |  |
| Observer's Name                                                                 |                               |  |  |  |

## Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

### Contact Information

|                                           |             |               |      |
|-------------------------------------------|-------------|---------------|------|
| Student's Name                            | School Year | Date of Birth |      |
| School                                    | Grade       | Classroom     |      |
| Parent/Guardian                           | Phone       | Work          | Cell |
| Parent/Guardian Email                     |             |               |      |
| Other Emergency Contact                   | Phone       | Work          | Cell |
| Child's Neurologist                       | Phone       | Location      |      |
| Child's Primary Care Doctor               | Phone       | Location      |      |
| Significant Medical History or Conditions |             |               |      |

### Seizure Information

1. When was your child diagnosed with seizures or epilepsy? \_\_\_\_\_

2. Seizure type(s) \_\_\_\_\_

| Seizure Type | Length | Frequency | Description |
|--------------|--------|-----------|-------------|
|              |        |           |             |
|              |        |           |             |
|              |        |           |             |
|              |        |           |             |

3. What might trigger a seizure in your child? \_\_\_\_\_

4. Are there any warnings and/or behavior changes before the seizure occurs? ☐ YES ☐ NO

If YES, please explain: \_\_\_\_\_

5. When was your child's last seizure? \_\_\_\_\_

6. Has there been any recent change in your child's seizure patterns? ☐ YES ☐ NO

If YES, please explain: \_\_\_\_\_

7. How does your child react after a seizure is over? \_\_\_\_\_

8. How do other illnesses affect your child's seizure control? \_\_\_\_\_

### Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? ☐ YES ☐ NO

If YES, what process would you recommend for returning your child to classroom:

### Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

#### For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

### Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? ☐ YES ☐ NO

If YES, please explain:

### A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

### Seizure Medication and Treatment Information

13. What medication(s) does your child take?

| Medication | Date Started | Dosage | Frequency and Time of Day Taken | Possible Side Effects |
|------------|--------------|--------|---------------------------------|-----------------------|
|            |              |        |                                 |                       |
|            |              |        |                                 |                       |
|            |              |        |                                 |                       |

14. What emergency/rescue medications are prescribed for your child?

| Medication | Dosage | Administration Instructions (timing* & method**) | What to Do After Administration |
|------------|--------|--------------------------------------------------|---------------------------------|
|            |        |                                                  |                                 |
|            |        |                                                  |                                 |

\* After 2<sup>nd</sup> or 3<sup>rd</sup> seizure, for cluster of seizure, etc.

\*\* Orally, under tongue, rectally, etc.

15. What medication(s) will your child need to take during school hours? \_\_\_\_\_

16. Should any of these medications be administered in a special way? ☐ YES ☐ NO

If YES, please explain: \_\_\_\_\_

17. Should any particular reaction be watched for? ☐ YES ☐ NO

If YES, please explain: \_\_\_\_\_

18. What should be done when your child misses a dose? \_\_\_\_\_

19. Should the school have backup medication available to give your child for missed dose? ☐ YES ☐ NO

20. Do you wish to be called before backup medication is given for a missed dose? ☐ YES ☐ NO

21. Does your child have a Vagus Nerve Stimulator? ☐ YES ☐ NO

If YES, please describe instructions for appropriate magnet use:

### Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

- |                                                     |                                                                |
|-----------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> General health _____       | <input type="checkbox"/> Physical education (gym/sports) _____ |
| <input type="checkbox"/> Physical functioning _____ | <input type="checkbox"/> Recess _____                          |
| <input type="checkbox"/> Learning _____             | <input type="checkbox"/> Field trips _____                     |
| <input type="checkbox"/> Behavior _____             | <input type="checkbox"/> Bus transportation _____              |
| <input type="checkbox"/> Mood/coping _____          | <input type="checkbox"/> Other _____                           |

### General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? \_\_\_\_\_

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ☐ YES ☐ NO

Dates \_\_\_\_\_

Updated \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_