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HILLSDALE 7-12
419-368-6841

CENTRAL OFFICE
419-368-8231

EMERGENCY ACTION PLAN FOR SEIZURE DISORDER

Student Name: _____ D.O.B. ____/____/____
 _____ School: _____ Grade: _____ Homeroom: _____

Parent/Guardian #1: _____ Cell Phone: (____) _____ - _____
 Parent/guardian #2: _____ Cell Phone: (____) _____ - _____
 Physician: _____ Office Phone: (____) _____ - _____
 Fax Number: (____) _____ - _____

Emergency Contacts if unable to reach parent:

Name: _____ Cell Phone: _____ Relationship: _____
 Name: _____ Cell Phone: _____ Relationship: _____

GREEN ZONE (<2 minutes)	YELLOW ZONE (2-5 minutes)	RED ZONE (>5 minutes)
<ul style="list-style-type: none"> * Start First Aid * Give Seizure Rescue Med * Allow student to recover from seizure * Notify parent/guardian * Return to class, or go home as per parent/guardian instructions 	<ul style="list-style-type: none"> * Continue First Aid * Call for help * Prepare to administer Seizure Rescue Medication * Provide privacy * Allow student to recover * Notify parent/guardian * Return to class, or go home as per parent/guardian instructions 	<ul style="list-style-type: none"> * Continue first Aid * Notify parent/guardian * Call 911: If seizure does not stop after rescue medication is given, seizure lasts longer than 10 minutes, loss of consciousness longer than 5 minutes, difficulty breathing, injury with seizure, or has seizure in water:

First Aid for Seizures:

- Stay calm, speak quietly and calmly
- Track time and duration of seizure; include start and stop time of seizure
- Keep student safe - remove harmful objects; do not put anything in mouth; remove eyeglasses and items around the neck
- Do not restrain, protect head, keep airway clear
- Turn on side, keep away from harmful objects (desks, chairs)
- Stay with student until fully conscious
- Follow school policy regarding notifying appropriate school personnel when a student has a seizure.

Seizure Types:

Seizure Type A: Myoclonic vs. Atonic - behavioral pauses, upper body jerks, head bobbing, eye blink/flutter, eye closure, may drop items

Seizure Type B: Generalized Motor - spasms, stiffening, jerking

Seizure Type C: Atypical Absence - confused, unresponsive, staring; can come and go quickly; observed as day dreaming

Medical Treatment:

Actions After a Seizure:

Physician Signature: _____ **Date:** _____

Phone Number: _____ **Fax:** _____

Parent/Guardian:

I give my permission for my child to receive seizure medication at school according to the school district policy and as instructed by my healthcare provider.

I agree and responsible to:

- Deliver my child's seizure medications to the school in its original container and labeled by a pharmacist or healthcare provider.
- Tell the school if my child gets a new healthcare provider
- Tell the school as soon as possible if there is a change in treatment or dosage of seizure medications.
- Have my healthcare provider complete a new medication form for my child if the medicine or dose changes
- Provide a new Seizure Action Plan from the healthcare provider at the beginning of each new school year with current medication orders.

I agree for my child's healthcare provider to talk with the school or any school staff personnel about my child's seizure medical plan. No other part of my child's medical health will be discussed.

Parent/Guardian Signature

Date

Parent/Guardian Printed Name

Parent/Guardian Cell Phone