

SEIZURE

Eastchester Union Free School District EMERGENCY ACTION PLAN

Student's name: _____ DOB: _____

Grade: _____

PHOTO ID

Mother/Guardian: _____

(H) _____

(C): _____

(W) _____

Father/Guardian: _____

(H) _____

(C): _____

(W) _____

Emergency Contact: _____

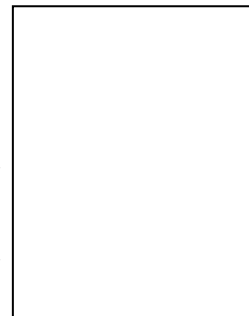
(H) _____

(C): _____

(W) _____

Physician student sees for seizures: _____ Phone: _____

Primary Care Physician: _____ Phone: _____



Check if student has orders for **Diastat** in school:

Restrictions (if any): _____ Check here if no restrictions

Emergency Intervention:	
<p><u>IF YOU SEE THIS:</u></p> <ul style="list-style-type: none"> ♦ May experience an aura (unusually sensation) or feeling immediately preceding seizure, such as: <ul style="list-style-type: none"> ▪ Visual hallucination ▪ Strange sound ▪ Lack of smell, strange smell ▪ Urgent need to get to safety Mild blackout Daydreaming ♦ Rhythmic jerking or stiffening of all or some of the extremities and face. ♦ Unresponsive during and for some time after the seizure episode. 	<p><u>DO THIS:</u></p> <ol style="list-style-type: none"> 1. Call School Nurse. 2. Wear gloves. Use infection control precautions. 3. Do not place anything in student's mouth. 4. Place on their side to prevent choking. 5. If student is standing or sitting, gently lower to ground to avoid a fall. 6. If possible, place a cushion or blanket under student's head. 7. Do not hold or restrain student. 8. Clear area around student to prevent injury from sharp objects. 9. Do not give food, drink or medication (unless given by the nurse with doctor orders) 10. Observe all of the student's activity during the seizure and record on seizure chart. 11. Stay with student at all times or designate another adult to do so.
<p><u>WHEN SEIZURE IS OVER:</u></p> <ul style="list-style-type: none"> • Monitor breathing. • Determine their level of awareness. • Check for injuries. • Provide for transportation and accompany student to Health Office. • Notify parent for immediate transport home. 	
<p><u>CALL 911 IF:</u></p> <ul style="list-style-type: none"> • Student's breathing is compromised in any way. • Seizure lasts longer than 5 minutes, or as indicated by physician orders. • Nurse is unavailable. 	

Comments/Special Instructions: _____

Signature of parent/guardian: _____

Date: _____

Signature of Health Care Provider: _____

Date: _____

Health Care Provider phone number: _____

Parent signature gives permission to speak to child's physician/practitioner and school staff as needed.