Salado ISD Health Services
Emergency Plan for Seizure
Guidance for Non-licensed School Personnel
Year _____

Place student pic

Student	DOB	SISD ID #	Grade/HR

Seizure type: ☐ Absence (staring, unresponsive) ☐Partial: Occurs while student is conscious
☐ Generalized tonic-clonic (grand mal, convulsive) ☐ Describe seizures:

Current meds to treat seizures	Date of last seizure	Length of last seizure

Safety measures:	Physical Restrictions: ☐ No☐ Yes (explain):

Seizure Emergency Medication needed at school:	Dosage/Route	Times	Expiration Date

Medication at school: ☐ N/A ☐ In Health Office

IF YOU SEE ANY OF THE FOLLOWING:

- Muscle twitching or tensing and alternately contracting and relaxing
- Speech disturbance, or inability to speak
- Abrupt changes in vision, hearing, or balance
- Paleness or flushing of the face
- Motionless stare or a sudden stop of activity
- Involuntary movement of eyes, head or other parts of the body
- Change in level of consciousness
  - Falling down without a reason

DO THIS:

- Call the office for assistance and ask for the nurse to go to the classroom.
- Assure the student's safety and move objects away that may cause injury.
- Do not walk student to clinic.
- Monitor student level of consciousness. If at any time student becomes unconscious, gently lower student to the floor and place on their side.
- **Do <u>not</u>** attempt to hold down / restrain the student.
- **Do <u>not</u>** attempt to place any object in their mouth.
- Take necessary action to prevent the student from hitting head and injuring self.
- Document time and duration of seizure activity.
- **If the student has emergency seizure medication, administer as directed and call 911.**

CALL 911
☐IF SEIZURE LASTS MORE THAN 5 MINUTES
☐IF SEIZURE REOCCURS
☐IF _____

<u>CONTACT PARENT AS SOON AS POSSIBLE</u>

Additional instructions:

PHYSICIAN/PARENTAL AUTHORIZATION FOR EMERGENCY PLAN FOR SEIZURE MEDICATION

Physician authorization: Print Name	Physician Signature	Physician Phone	Date

I grant permission to SALADO ISD to administer this medication to my child. I am giving permission to SISD staff to contact my physician for additional information if necessary. If the school nurse deems it necessary, I grant permission to notify my child's teacher(s) of his health condition. I understand that a medically untrained designee of the principal may give the medication.

Parent/Guardian	Best emergency phone	Other phone	Date
Emergency contact	Phone	Phone	
Plan Developed by(nurse):	**Date**	**Caregiver Trained**	**Date**
Caregiver Trained	**Date**	**Caregiver Trained**	**Date**
Caregiver Trained	**Date**	**Caregiver Trained**	**Date**

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Student Name	DOB	SISD #	Grade/Homeroom	Bus #

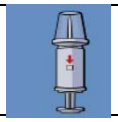
Seizure: Care Plan Review

Printed Name	Signature	Position	Date	Initials

HOW TO USE DIASTAT: EMERGENCY SEIZURE MEDICATION

Retrieve emergency Diastat kit and open

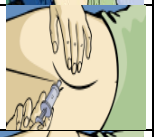
Remove syringe and remove cap



Lubricate with package in kit

Place student on their side and separate & insert syringe into buttocks

Count to 3 while pushing plunger before removing syringe



Remove syringe and count to 3 while holding buttocks together