717 JORDAN PUBLIC SCHOOLS
500 Sunset Drive
Jordan, Minnesota 55352
952-492-6200 main | 952-492-4445 fax

DISTRICT NURSE
jordannurse@isd717.org

SEIZURE EMERGENCY CARE PLAN

Dear Parent(s) Guardians of: _____

According to our recent records you have indicated that your child has a history of seizures. To best care for your child while he/she is in school, please fill out the **Seizure Questionnaire** and have his/her physician fill out the **Seizure Emergency Care Plan** before the start of the school year.

The forms on the following pages must be completed and signed before the start of school.

Please return the enclosed forms as soon as possible either by mailing, faxing or in person at the following school so that we may best care for your child should the need arise:

_____ **Jordan Elementary School**	Address: 815 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4446
_____ **Jordan Middle School**	Address: 500 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4450
_____ **Jordan High School**	Address: 600 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4425

In accordance with Minnesota law (121A.24), *every student with a reported diagnosis of seizures must have an emergency care plan in place.* ***If you do not return a care plan for your student, we will implement a generalized seizure plan that will include seizure first aid and contacting Emergency Medical Services for all seizure activity.***

Please call or email us if you have any questions or concerns.

Thank you,

Darci Griffiths MSN, RN, LSN
District Nurse - JHS
952-492-4410
jordannurse@isd717.org
Fax: 952-492-4425

Jenn Passe, RMA
Jordan Middle School
952-492-4232
Fax: 952-492-4450

Jenna Hentges, RN
Jordan Elementary School
952-492-4278
Fax: 952-492-4446

Seizure Questionnaire - Independent School District 717

Student Name: _____ DOB: _____

Grade: _____ Teacher: _____

SEIZURE HISTORY

1. What type of seizures does your child experience? **Please check all that apply:**
   - ❑ **Focal Aware** - Remains conscious, sensory, rhythmic movements, changes in thinking or feeling
   - ❑ **Focal Impaired Awareness**- Altered consciousness, repetitive purposeless movement, blank stare
   - ❑ **Generalized Tonic-Clonic** - Sudden cry or moan, loss of consciousness, rigid body with rhythmic shaking
   - ❑ **Atonic** - Abrupt loss of postural tone, loss of consciousness
   - ❑ **Myoclonic** - Brief random contractions of a muscle group, no loss of consciousness.
   - ❑ **Absence** - Brief and sudden lapse of awareness.
   - ❑ **Tonic** - Stiffening of the entire body musculature
   - ❑ **Other** _____
2. What triggers have been identified?_____
3. When was the last time your child had a seizure?_____
4. When was the last time emergency seizure medication was given?_____
5. How long do seizures typically last?_____
6. Does your child recognize the signs of an impending seizure? ❑ Yes ❑ No
7. Is your child able to alert an adult if he/she feels a seizure is about to happen? ❑ Yes ❑ No
8. What care is needed after a seizure? _____
9. How long before he/she is able to return to normal activities?_____
10. List daily seizure medication (if any)_____
11. Implanted device? ❑ None ❑ VNS ❑ RNS ❑ DBS Date implanted:_____
12. Epilepsy surgery (please describe)_____
13. Diet Therapy? ❑ None ❑ Ketogenic ❑ Low glycemic ❑ Modified Atkins ❑ Other_____
14. Allergies:_____

Parent Name _____(h) _____ (w) _____ (c)_____

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Seizure Emergency Care Plan

Student Name: _____ DOB: _____ Grade: _____

Seizure First Aid (Stay, Safe, Side):

- ❑ **STAY** CALM - *begin timing the seizure*
- ❑ **Safe** - remove harmful objects, don't restrain, protect head
- ❑ **Side** - turn on side if not awake, keep airway clear, don't put objects in mouth
- ❑ **Stay** until recovered from seizure
- ❑ Swipe magnet for VNS
- ❑ Write down what happens_____
- ❑ Other: _____

When to call 911:

- ❑ Seizure with loss of consciousness longer than 5 min, not responding to rescue med
- ❑ Repeated seizures longer than 10 min with no recovery time in between, not responding to rescue med
- ❑ Difficulty breathing after a seizure
- ❑ Serious injury occurs or is suspected
- ❑ Seizure in water

Emergency Medication Orders

Give EMERGENCY MEDICATION if seizure lasts LONGER than _____ minutes or_____

-Emergency Medication:_____ Dose_____ Route _____

Frequency _____

-Emergency Medication:_____ Dose_____ Route _____

Frequency _____

Other instructions_____

_____

Physician Signature_____**Date**_____

I want this plan implemented for my child while in school. I give permission for exchange of confidential medical information between school staff and my child's health care providers on a need to know basis. I release school personnel from liability in the event adverse reactions result from implementation of the above emergency plan and subsequent administration of emergency medication(s). I give permission for school staff to call 911 if necessary.

Parent Name _____ (w) _____ (c)_____

Parent Name _____ (w) _____ (c)_____

Emergency Contact _____ (w) _____ (c)_____

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____