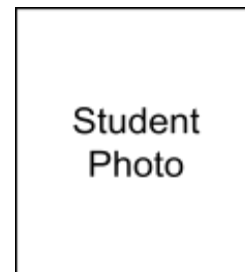




Seizure Action Plan



LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

SEIZURE TYPE (Parent/Guardian: description of seizure type(s), occurrence pattern and episode length)

<p>Absence (petit mal) A period of unconsciousness with a blank stare or what looks like daydreaming. The person may lose muscle control and make repetitive movements.</p> <p>Frequency: _____ Duration: _____</p>	<p>First aid for any seizure</p> <ul style="list-style-type: none"> • STAY calm, keep calm, and time seizure • Keep the child SAFE - remove harmful objects, don't restrain, protect head • SIDE - turn on side if not awake, keep airway clear, don't put any objects in child's mouth • STAY with the child until recovered from seizure • Document the seizure occurrence <p>When to call 911</p> <ul style="list-style-type: none"> ✓ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med, if available ✓ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med, if available ✓ Difficulty breathing after seizure ✓ Serious injury occurs or suspected, seizure in water
<p>Myoclonic Consciousness and memory are not impaired. Muscle jerks may occur in parts or all of the body.</p> <p>Frequency: _____ Duration: _____</p>	
<p>Tonic-clonic/convulsive (grand mal) The child will lose consciousness from the start of the seizure. The muscles will stiffen (tonic phase), causing him/her to fall to the floor. The extremities then jerk and twitch rhythmically (clonic phase). Child may froth at the mouth. Breathing may be irregular. The person will regain consciousness slowly.</p> <p>Frequency: _____ Duration: _____</p>	
<p>Other: _____ Not described by the seizure types listed above</p> <p>Frequency: _____ Duration: _____</p>	

TRIGGERS OR WARNING SIGNS

Stress
 Lack of sleep
 Intense Emotions
 Boredom
 TV/Laptop/Phone/Tablet
 Fever
 Flashing lights
 Bright lights
 Other: _____

CHILD'S RESPONSE FOLLOWING SEIZURE

EMERGENCY MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY	INDICATION
<input type="checkbox"/> Diazepam				For seizures lasting longer than ___ minutes.
<input type="checkbox"/> Midazolam				For seizures lasting longer than ___ minutes.
<input type="checkbox"/> Other:				

ADDITIONAL CONSIDERATIONS

Allowed to participate in usual school activities, including physical education.
 Has vagal nerve stimulator. Describe: _____
 Requires special consideration or safety precautions. Describe: _____

MEDICAL PROVIDER NAME/TITLE	PHONE
MEDICAL PROVIDER SIGNATURE	DATE

THIS AUTHORIZATION EXPIRES AT THE END OF THE SCHOOL YEAR AND MUST BE RENEWED EACH FALL

Adapted and reprinted with permission from the Anchorage School District



Seizure Action Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
-----------	------------	------	---------------

DAILY SEIZURE TREATMENT PROTOCOL			
PRESCRIBED DAILY MEDICATION	DOSE	HOME or SCHOOL	COMMON SIDE EFFECTS

PARENT/GUARDIAN AGREEMENT AND AUTHORIZATION

I request that the medication(s) selected and seizure protocols listed on this plan be provided to my student. I will provide needed medication(s) or supplies for care in school. **Prescription medication must be in the original pharmacy container labeled with the following information: name, medication, dosage, route, administration time, ordering healthcare provider, pharmacy, date issued, and prescription number.** I understand and approve that, in the absence of the Health Services team member, other trained Fairbanks North Star Borough School District ("FNSBSD") personnel may administer this medication.

Employees and agents of FNSBSD strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless FNSBSD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify FNSBSD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the healthcare practitioner listed above and FNSBSD as part of the provision of my student's care. I agree for the Health Services team member to share health information with FNSBSD staff on a need-to-know basis for my student's safety and to foster academic success. I understand that ANY remaining medication(s) will be disposed of at the end of the school year, unless I pick up the remaining medication(s) by the last school day, as indicated on the FNSBSD school year calendar.

THIS CARE PLAN EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL.

PARENT/GUARDIAN NAME	RELATIONSHIP TO STUDENT	PHONE NUMBER
PARENT/GUARDIAN SIGNATURE		DATE

NURSE PLAN REVIEW

I have reviewed the Seizure Care Plan for accuracy and ensure that all required fields and signatures are completed before administering medication to a student. I approve of the agreement arranged between the physician, parent, nurse, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME	
NURSE SIGNATURE	DATE