

Acute Seizure Action Plan

Name: _____	Birth date: _____	Today's date: _____
Care partner phone numbers: _____	Provider name/facility: _____	Provider phone numbers: _____



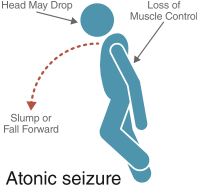
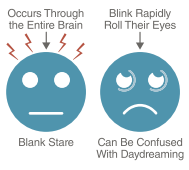
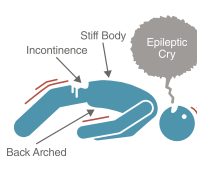
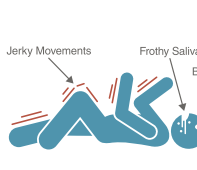
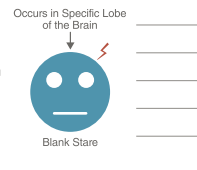
Usual Seizure Pattern

Triggers: _____

Pattern of seizures: _____

Allergies: _____

What the seizures normally look like (Check all that apply)

 <p>Head May Drop Loss of Muscle Control Slump or Fall Forward</p>	 <p>Occurs Through the Entire Brain Blink Rapidly Roll Their Eyes Blank Stare Can Be Confused With Daydreaming</p>	 <p>Incontinence Stiff Body Epileptic Cry Back Arched</p>	 <p>Jerky Movements Frothy Saliva Blinking Eyes</p>	 <p>Occurs in Specific Lobe of the Brain Blank Stare</p>
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Describe: _____






Atonic seizure (also called drop)
 Absence seizure (also called petit mal)
 Tonic seizure
 Clonic seizure
 Focal impaired awareness seizure (also called complex partial)

NOTES: _____

Care




Standard Care Needed

If this happens, _____ provide standard care












 <p>Time the seizure</p> <p>NOTES: _____</p>	 <p>Keep person safe</p> <p>NOTES: _____</p>	 <p>Don't restrict</p> <p>NOTES: _____</p>	 <p>Stay with person</p> <p>NOTES: _____</p>	 <p>Keep a record</p> <p>NOTES: _____</p>
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Provide Rescue Treatment

If this happens, _____ provide standard care (above) **and** rescue treatment

 <p><input type="checkbox"/> Rectum</p>	 <p><input type="checkbox"/> Nose</p>	 <p><input type="checkbox"/> Mouth</p>	<p>Specific instructions: _____</p> <p><input type="checkbox"/> Other: _____</p>
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Call for Emergency Help

<p style="text-align: center;">If any of these happen,</p> <table style="width: 100%;"> <tr> <td style="width: 33%; text-align: center;">  <p><input type="checkbox"/> Seizure longer than _____ minutes</p> </td> <td style="width: 33%; text-align: center;">  <p><input type="checkbox"/> Unusual seizure</p> </td> <td style="width: 33%; text-align: center;">  <p><input type="checkbox"/> Injury/Blue lips</p> </td> </tr> </table> <p><input type="checkbox"/> Other: _____</p> <p>NOTES: _____</p>	 <p><input type="checkbox"/> Seizure longer than _____ minutes</p>	 <p><input type="checkbox"/> Unusual seizure</p>	 <p><input type="checkbox"/> Injury/Blue lips</p>	<p style="text-align: center;">Get help now</p> <div style="text-align: center;">   </div> <p>Call Healthcare Provider if: _____</p> <p>Call for Emergency Help if: _____</p> <p>NOTES: _____</p>
 <p><input type="checkbox"/> Seizure longer than _____ minutes</p>	 <p><input type="checkbox"/> Unusual seizure</p>	 <p><input type="checkbox"/> Injury/Blue lips</p>		

Healthcare Provider Authorization

Signature: _____ Provider Printed Name: _____ Date: _____ For use from: _____ to: _____



Emergency or Routine Seizure Medication

Student's name: _____ Birthdate: _____ School/Grade/Teacher: _____

- The student's Ohio licensed health care prescriber must complete and sign Section I of this form each school year.
- Parent/guardian must complete and sign Section II of this form each school year.
- This completed form must be on file in the student's health record before medication will be administered by school personnel.
A separate form is required for each medication.
- Medication must be in the original container as dispensed by the physician, pharmacist, or manufacturer. This medication will be stored in the school clinic unless prescriber authorizes the student to self-carry the medication.

I. Prescriber's Section

Prescriber's name/title (printed): _____ Phone: _____

This is to certify that the student named above is under my care and should receive the following medication at the following times during the school day:

Medication name and strength	
Dose	
Route	
Time / circumstances for administration	
Severe adverse reactions to be reported to prescriber	
Adverse reaction for an unauthorized user	
Special instructions for administration	
Possible side effects	
Procedure to follow if medication doesn't produce desired effects:	
Special storage instructions	
Other special instructions	
Starting & ending date of this request	Start _____ End _____

Prescriber's signature/title: _____ Date: _____

Address: _____ Emergency contact #: _____

II. Parent/Guardian's Section

I hereby request and give my permission for school district personnel to administer this prescribed medication to my child in accordance with the specific written orders from our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of this medication to the school clinic and will notify the school (if applicable) immediately if we change our medical provider or the need for this medication is discontinued.

I agree to submit a revised *Emergency or Routine Seizure Medication* (form 5330 F1a) if any changes are made regarding the above medication.

I understand this medication can only be administered to my child by a school nurse, myself, or this student until medically unlicensed staff in my child's school have completed the required District training. In the absence of a medically licensed person, such as a school nurse, only designated, trained staff are authorized to perform this task.

If this medication is required for extracurricular activities, I agree to provide a separate dose to school staff supervising my child's extracurricular activities.

I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers as necessary for medical management.

Parent/Guardian signature: _____ Date: _____

Home address: _____ Daytime phone: _____

