School Nursing
Seizure Emergency Action Plan

Medications may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

Photo

I, the parent/guardian of _____date of birth_____ request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I fully realize I can withdraw my request/consent in writing at any future date. I give permission to share, if necessary, this information with school personnel who may be involved with the welfare of my child.

As a parent, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy. And/or any supplies needed to administer the medication
2. To provide the school with the written doctor's instructions for medication administration during school hours. And that medication will not be administered until signed doctors instructions are at school
3. To inform the school of any medical changes.
4. I will assume responsibility for safe delivery of the medication to school
5. To provide the school with this signed consent form annually and when changes in medication occur.
6. I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damage or injury resulting directly or indirectly from this authorization.
7. If your child is Medicaid eligible, school health services may bill on behalf of the school. School district billing will not impact future benefits of your family's Medicaid plan. This would include releasing Personally Identifiable Information (PII) about my child (including date of birth, disability, gender, school, date of services, type of services) to Michigan Medicaid and its billing agencies for Medicaid reimbursement of School-Based Services.

Significant medical history:_____

Seizure Type	***Length***	***Frequency***	***Description***

Seizure triggers or warning signs:_____

_____

Student's reaction to seizure:_____

_____

A "seizure emergency" for this student is defined as: _____

_____

Procedure for student after seizure: _____

_____

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- ☐ Activate school MERT (medical emergency response team)
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Complete seizure observance record. Copy to physician.
- ☐ Other_____

Basic Seizure First Aid:

- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:

- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn on side so secretions run out
- ✓ Give medication if ordered and as directed

A Seizure is generally considered an Emergency when:

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water
- ✓ Change in type or frequency of seizure

School Nursing
Seizure Individualized Health Plan

Daily Medication	Dosage & Time of Day Given	

Emergency Medication	Dosage	Common side Effects and special Instructions

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO
If YES, Describe magnet use_____

Special Considerations/Precautions (regarding school activities, sport, trips, etc.)_____

I have discussed and developed a plan, with the school nurse, for appropriate support during school emergencies.

Parent/Guardian: _____ Relationship: _____ Date: _____

Emergency Contact Phone Number: _____

PLEASE REVIEW PARENT PROVIDED INFORMATION, SIGN AND RETURN

_____ _____
Physician's name printed Physician's signature

Physician's address: _____

Phone: _____ Fax:_____Date: _____

If Seizure of Any Type Occurs:

- Remain Calm! And reassure others who may be nearby.
- Remove other students from classroom.
- Loosen clothing at neck and waist; remove eyeglasses (if applicable); protect head with arms, lap, cushioning material
- Clear away furniture and other objects from area
- TIME the seizure and document event on seizure observance record.
- Allow seizure to run its course; DO NOT restrain or insert anything into student's mouth. DO NOT try to stop purposeless behavior
- Administer emergency medication per doctor's order.

Seek Emergency Care *(Call 911 and parent)* If a Child Experiences any of the Following:

- Absence of breathing and/or pulse
- Seizure of 5 minutes or greater duration (or as described in student's health plan)
- Two or more consecutive (without a period of consciousness between)
- No previous history of seizure activity
- Continued unusually pale or bluish skin/lips or noisy breathing after the seizure has stopped
- Student is injured during seizure
- Has seizure in water.

Call 911 at onset of seizure if in IHP per parent request or physician order

Reference: Epilepsy Foundation of America, Inc