SEIZURE CARE PLAN AND MEDICATION – VNS ORDERS Plan ___ of ____

NAME:		Birthdate:	School:	
Grade:	Preferred Hospital:	☐ Bus #	☐ Walk ☐Drive	Weight:
History (including current medication):				

TYPES of SEIZURES

Tonic Clonic	Absence	Psychomotor
Muscles tense, body rigid, followed by a temporary loss of consciousness and violent shaking of entire body. **Comments:**	Staring spells. May drop an object s(he) is holding or may stumble momentarily. **Comments:**	Some degree of impairment of consciousness-- may have automatic movements like lip smacking, roaming, and non-goal oriented activity. **Comments:**
*IDENTIFY students usual signs/symptoms	*IDENTIFY students usual signs/symptoms	*IDENTFY students usual signs/symptoms

IF YOU SEE THIS	DO THIS Adult stays with student at all times
ABSENCE **AND** **PYSCHOMOTOR SEIZURES**	Time seizure and monitor student closely. Notify the nurse_____and parent/guardian_____. Gently support and protect student from harm. Do not restrain. No first aid is needed if no injury. After seizure, calmly re-orient student to their surroundings. After seizure, record seizure activity on Seizure Observation Log.
TONIC CLONIC **Do not hold student down** **Do not put anything in their mouth** (for loss of bowel/bladder, cover with blanket for privacy)	Time seizure activity. Stay calm & ease student to floor to avoid a fall. If trained, administer medication/treatments as ordered below. Clear area around student-move hard objects. Keep others away. Support student on their left side to allow vomit/drool to drain. Loosen clothing around neck. Place soft material under head. Notify the nurse_____and parent/guardian_____. After seizure record events on the Seizure Observation Log.

CALL 911 IF:

- Seizure does not stop by itself or is first tonic clonic seizure.
- Seizure does not stop within_____minutes.
- Child does not start waking up within_____minutes after seizure is over.
- Another seizure starts immediately after the first seizure.
- Bluish color to lips AFTER seizure ends.
- Prolonged loss of consciousness.
- Stops breathing **(START RESCUE BREATHING/CPR).**

_____has a Vagus Nerve Stimulator (VNS) implanted in their neck. You will see the VNS under the skin on their LEFT chest. It turns on and off at intervals of _____ minutes at this time. When they have a seizure, a magnet (located: _____) is to be "swiped" across the VNS in the students left chest area.

**** While the VNS is on, you may hear a change in their voice. This is nothing to worry about and is normal****

TREATMENT/MEDICATION ORDERS: VNS Magnet Instructions

- If child is having repetitive seizures, or a tonic clonic seizure, swipe the magnet across the VNS in the chest area counting "one- one thousand-one." The stimulation that is triggered lasts 60 seconds.
- If the seizure is still going on after one minute, you may repeat. Usually the seizure is over after one or two swipes.
- If the seizure is still going after 2 swipes of the magnet, call 911 and administer emergency rescue medication, **if ordered**:
- _____ (medication) _____mg_____ (route).
- Daily seizure medication: _____ Dose _____ Time _____
  ☐ Takes seizure medication at home ☐ Takes seizure medications at school

LHP Signature	Date:	Telephone: Fax Number:
LHP Printed Name	Start Date:	End Date:

*****Document seizure activity on Seizure Observation Log (attached)*****

EMERGENCY CONTACTS

Parent/Guardian	
Name:	Name:
Primary #:	Primary #
Other #	Other #
Other #	Other #

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Accommodations needed_____ No _____ Yes If yes, list below:

- A new EAP and medication/treatment orders for seizures must be submitted each school year.
- If any changes are needed on the EAP, it is the parent/guardian's responsibility to contact the school nurse.
- It is the parent/guardian's responsibility to alert all other **non-school** programs of their child's health condition.
- Medical information may be shared with school staff working with my child and 911 staff, if they are called.
- I have reviewed the information on this Seizure Emergency Action Plan/504 and medication/treatment orders and request/authorize trained school employeesto provide this care and administer medication/treatments in accordance with the Licensed Healthcare Provider's (LHP's)instructions.
- This is a life-threatening plan and can only be discontinued by the LHP.
- I authorize the exchange of information about my child's seizure disorder between the LHP office and the school nurse.
- *My signature below shows I have reviewed and agree with this health care/504 plan and medication/treatment orders.*

Parent/Guardian Signature Date

EXPECTED POST-SEIZURE BEHAVIOR

- Tiredness
- Weakness
- Sleeping
- Difficult to arouse
- May be somewhat confused
- Regular breathing
- This period may last a few minutes or hours

For District Nurse's Use Only **504 Plan**

A registered nurse has completed a nursing assessment and developed this Seizure Care Plan in conjunction with this student, their parent/guardian and their LHP.

Medication/Device(s)	**Expiration date(s):**

School Nurse Signature **Date:** **Phone:**

Health care/504 plan and medication (if prescribed) must accompany student on any field trip or school activity.
***** Keep plan readily available for Substitutes. *****

SEIZURE OBSERVATION LOG

Student Name:				
Date / Time:				
Seizure Length:				
Pre-Seizure Observation (briefly list behaviors, triggering events, activities):				
Conscious (yes/no/altered):				
Injuries (briefly describe):				
Muscle tone/body movements	Rigid/clenching			
	Limp			
	Fell down			
	Rocking			
	Wandering around			
	Whole body jerking			
Extremity movements	(R) arm jerking			
	(L) arm jerking			
	(R) leg jerking			
	(L) leg jerking			
	Random movement			
Color	Bluish			
	Pale			
	Flushed			
Eyes	Pupils dilated			
	Turned (R or L)			
	Rolled up			
	Staring or blinking (clarify)			
	Closed			
Mouth	Salivating			
	Chewing			
	Lip smacking			
Verbal sounds (gagging, talking, throat clearing, etc.)				
Breathing (normal, labored, stopped, noisy, etc.)				
Incontinent (urine or feces)				
Post-seizure observation	Confused			
	Sleepy/tired			
	Headache			
	Speech slurring			
	Other			
Length of time to orientation:				
Parent/guardian notified (time of call):				
9-1-1 called (call time & arrival time):				
Staff member observing seizure (name):				