SEIZURE CARE PLAN AND MEDICATION 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 the 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 student's usual signs/symptoms**	***IDENTIFY student's usual signs/symptoms**	***IDENTIFYstudent'ss usual signs/symptoms**

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

TREATMENT/MEDICATION ORDERS

- For seizure lasting over _____minutes **OR** for_____or more _____(type) seizures in_____minutes/hours **OR**
- The child does not start waking up within_____minutes after the seizure is over
- _____ (medication) _____mg _____ (route) for _____(type)
  for intra-nasal midazolam: give _____ml divided---1/2 dose (_____ml) into each nostril
- Call 911 when seizure emergency medication has been administered
- Daily seizure medication: _____ Dose: _____ Time: _____
  ☐ Takes seizure medication at home ☐ Takes seizure medication at school

***Medications will be administered by the registered nurse, parent, or PDA.

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

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 order 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 EMS 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 the 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)				