Valdez City Schools
PO Box 398
1112 West Klutina – Valdez, AK 99686
Telephone (907) 835-4357
Fax (907) 835-4964

SEIZURE CARE PLAN

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

SEIZURE TRIGGERS OR WARNING SIGNS

☐ Stress ☐ Intense emotions ☐ Boredom ☐ Lack of sleep
☐ Fever ☐ Television, videos, or flashing lights ☐ Other: _____

SEIZURE TYPE	LENGTH	FREQUENCY	DESCRIPTION
☐ Absence seizures (petite mal)			A period of unconsciousness with a blank stare or what looks like daydreaming. The person may lose muscle control and make repetitive movements.
☐ Tonic-clonic or convulsive seizures (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 will then jerk and twitch rhythmically (clonic phase). Child may froth at the mouth. Breathing may be irregular. The person will regain consciousness slowly.
☐ Myoclonic seizures			Consciousness and memory are not impaired. Muscle jerks may occur in parts or all of the body.
☐			

CHILD'S RESPONSE AFTER A SEIZURE: _____

MEDICAL PROVIDER AUTHORIZATION
(Provider have parent/guardian sign Authorization & Agreement page 2-2)

BASIC SEIZURE FIRST AID		SEIZURE EMERGENCY PROTOCOL
• Stay calm and track time • Keep the child safe • Do not restrain the child • Do not put anything in the child's mouth • Stay with the child until fully conscious • Document the seizure occurrence	**For a tonic-clonic or convulsive seizure** • Protect the child's head • Keep airway open • Watch breathing • Turn child on side	If child has a tonic-clonic or convulsive seizure lasting longer than 5 minutes, repeated seizures without regaining consciousness, is injured, has diabetes, has breathing difficulties, or the seizure occurs in the water... • CALL 911 and ADMINISTER EMERGENCY MEDICATION AS PRESCRIBED.

MEDICATION	USE	DOSE	ROUTE
☐ Diazepam (Diastat)	For seizures lasting _____ minutes or longer.		Rectal
☐ Midazolam	For seizures lasting _____ minutes or longer.		☐ Buccal ☐ Intranasal
☐ Other_____	For seizures lasting _____ minutes or longer.		Specify Route:_____

☐ YES ☐ NO **Does this child have a vagal nerve stimulator (VNS)?**
Please describe use: _____

☐ YES ☐ NO **Is this child allowed to participate in usual school activities including physical education?**

☐ YES ☐ NO **Does this child require any special considerations or safety precautions?**
Please explain: _____

MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY IN ALASKA (PRINTED)	TELEPHONE NUMBER
MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

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PARENT / GUARDIAN AGREEMENT & AUTHORIZATION

I request that the medication(s) selected and seizure protocols listed on this plan be provided to my child. **I will provide needed medications or supplies for care in school.**

Employees and agents of the Valdez City Schools (VCS) strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless VCS 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 VCS immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and VCS as part of the provision of my child's care. I agree for the nurse to share health information with VCS staff on a need-to-know basis for my child'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 VCS school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

EMERGENCY CONTACTS

NAME	RELATIONSHIP TO CHILD	PHONE NUMBER

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.

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 child. I approve of the agreement arranged between the physician, parent, nurse, and child for the management of the child's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the child in the school setting.

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE