SEIZURE

Mamaroneck Union Free School District
Emergency Action Plan

Add Student Photo

Student's Name:_____**DOB:** _____

Grade/Class_____

School: ☐ Central ☐ Chatsworth ☐ Mamaroneck Avenue ☐ Murray ☐ Hommocks ☐ MHS

Contact	Name	Home (H)	Cell (C)	Work (W)
Mother/Guardian				
Father/Guardian				
Emergency Contact				

Physician student sees for seizures: _____ **Phone:** _____

Primary Care physician: _____ **Phone:** _____

***Check if student has medication orders for Diastat/Valtoco/Nayzilam in school: Yes** ☐ **No** ☐

***Check if student <u>does not</u> require rescue medication on the bus to/from school:** ☐

***Check if no trained personnel or caregiver is present to administer rescue medication (i.e. on the bus, field trips, school-sponsored activities): PLEASE CALL 911 at Seizure Onset** ☐

***Restrictions (if any):** _____ ☐ **Check here if no restrictions**

Emergency Intervention If you see this:	**Do This:**
May experience an aura (unusual sensation) or feeling immediately preceding seizure, such as: • Visual hallucination • Strange sound • Lack of smell, strange smell • Urgent need to get to safety • Mild blackout • Daydreaming • Rhythmic jerking or stiffening of all or some extremities and the face. • Unresponsive during and for some time after the seizure episode.	1. Call the School Nurse. 2. Wear gloves. Use infection control precautions. 3. Do not place anything in the student's mouth. 4. Place on their side to prevent choking. 5. If the student is standing or sitting, gently lower to the ground to avoid a fall. 6. If possible, place a cushion or blanket under the student's head. 7. Do not hold or restrain the student. 8. Clear the area around the student to prevent injury from sharp objects. 9. Do not give food, drink, or medication (unless given by the nurse with doctor orders). 10. Observe all the student's activity during the seizure and record it on the seizure chart. 11. Always stay with the student or designate another adult to do so.
WHEN SEIZURE IS OVER: • Monitor breathing. • Determine their level of awareness. • Check for injuries. • Provide for transportation and accompany the student to the Health Office. • Notify parent for immediate transport home.	**CALL 911 IF:** • Student's breathing is compromised in any way. • Seizure lasts longer than 5 minutes, or as indicated by physician orders. • Nurse is unavailable.

Comments/Special Instructions: _____

Signature of Parent/Guardian: _____ **Date:** _____

Signature of Health Care Provider: _____ **Date:** _____

Health Care Provider phone number: _____ **Stamp :** _____ **Date:** _____

Parent/Guardian signature authorizes communication with the child's physician/practitioner and school staff, as needed.

Parent-Please complete the other side of the form

MAMARONECK UNION FREE SCHOOL DISTRICT

PARENT SEIZURE INFORMATION FORM

Dear Parents/Guardians:

Please complete the information below and return it to the Health Office as soon as possible. If any changes occur during the school year, please notify the School Nurse.

Name of Student: _____ Grade: _____

General History:

- How old was your child when he/she experienced their first seizure? _____
- How did you know your child was having a seizure? What symptoms did they exhibit? _____
  _____
- Date of most recent seizure: _____ Date last seen by doctor: _____
- How often does your child have seizures? _____
- Does he/she experience an aura? If yes, please explain. No: __ Yes:_____
- Do you know why your child has seizures?

__ Epilepsy __ Injury or trauma to the head __ Infection __ Brain tumor __ High fevers __ Stroke __ Unknown

__ other: _____

- How do you know your child is having a seizure now? What symptoms do they exhibit? _____
  _____
- How long do the seizures usually last? _____
- What happens to your child after he/she has a seizure? _____
- Has the doctor given a name to the type of seizure your child has? No: ___ Yes (Name): _____
- Are there any restrictions because of his/her diagnosis of seizures (i.e. driving, swimming, biking)? If yes, what are the restrictions? None: __ Yes: _____
- Medications child takes at home for seizures:

Name	Dose	How often
_____	_____	_____
_____	_____	_____

Side effects of medication that your child experiences: _____

- Following a seizure have you ever had to:

__ Give emergency medication, Diastat/Valtoco/Nayzilam? __ Call 911 for transport to the hospital?

- Additional information/instructions: _____

Thank you for your help in providing the best care for your student.

Signature of Parent/Guardian: _____ Date: _____

Parent-Please complete the other side of the form