SEIZURE ACTION PLAN FOR SCHOOL

Student Name_____D.O.B._____ ID # _____

School _____Teacher_____

Physician _____ Phone: _____

Student Picture

EMERGENCY CONTACTS

Name	Relationship	Home #	Work #	Cell #
1.				
2.				
3.				

Type of seizure: _____

What does the seizure look like and how long does it usually last?_____

_____

Possible triggers that should be avoided: _____

_____

Does student need any special activity adaptations/protective equipment (e.g., helmet) at school?

_____No _____Yes (explain)_____

_____

Is student allowed to participate in physical education and other activities? _____ No _____ Yes (explain)

_____

ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES? _____No _____Yes (List below the medications needed)

MEDICATIONS	**AMOUNT TAKEN**	**HOW OFTEN AND FOR WHAT SIGNS**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

List medication needed at school (name, dosage/route, and frequency) _____

_____

Possible side effects that must be reported to parent or physician: _____

_____

IF GENERALIZED SEIZURE OCCURS:

1. If falling, assist student to floor, turn to side.
2. Loosen clothing at neck and waist; protect head from injury.
3. Clear away furniture and other objects from area.
4. Have another classroom adult direct students away from area.
5. TIME THE SEIZURE.
6. Allow seizure to run its course; DO NOT restrain or insert anything into student's mouth. Do not try to stop purposeless behavior.
7. During a general or grand mal seizure expect to see pale or bluish discoloration of the skin or lips. Expect to hear noisy breathing.

IF SMALLER SEIZURE OCCURS (e.g., lip smacking, behavior outburst, staring, twitching of mouth or hands)

1. Assist student to comfortable, sitting position.
2. Time the seizure.
3. Stay with student, speak gently, and help student get back on task following seizure.

IF STUDENT EXHIBITS:

1. Absence of breathing or pulse.
2. Seizure of 10 minutes or greater duration.
3. Two or more consecutive (without a period of consciousness between) seizures which total 10 minutes or greater.
4. Continued unusually pale or bluish skin or lips or noisy breathing after the seizure has stopped.

INTERVENTION:

1. Call 911.
2. START CPR for absent breathing or pulse.

WHEN SEIZURE COMPLETED:

1. Reorient and assure student.
   a. Assist change into clean clothing if necessary.
   b. Allow student to sleep, as desired, after seizure.
   c. Allow student to eat, as desired, once fully alert and oriented.
2. A student recovering from a generalized seizure may manifest abnormal behavior such as incoherent speech, extreme restlessness, and confusion. This may last from five minutes to hours.
3. Inform parent immediately of seizure via telephone conversation if:
   a. Seizure is different from usual type or frequency or has not occurred at school in past month.
   b. Seizure meets criteria for 911 emergency call.
   c. Student has not returned to "normal self" after 30-60 minutes.
4. Record seizure on Seizure Activity Log.

If you want additional care given, describe action here:

If symptoms are _____

_____

Give_____
(medication/dose/route)

Possible side effects_____

_____

Physician Signature_____ Date_____
Print Name_____ Phone_____

❑ I want this plan implemented for my child, _____, in school. I hereby give my permission for exchange of confidential information contained in the record of my child between the nurse and physician and my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

Parent/Guardian Signature: _____ Date: _____

❑ Approved by School Nurse
School Nurse Signature: _____ Date: _____

STUDENTS WITH SPECIAL HEALTH CARE NEEDS
EMERGENCY PLAN NON-MEDICAL STAFF

STUDENT NAME :_____DOB:_____TEACHER:_____RM/GRADE :_____

PARENT/GUARDIAN:_____PREFERRED HOSPITAL:_____

HOME PHONE #:_____WORK #:_____ CELL #:_____

EMERGENCY CONTACT:_____ PHONE:_____OTHER PHONE:_____

PHYSICIAN:_____ PHYSICIAN TEL:_____ PHYSICIAN FAX:_____

STUDENT-SPECIFIC EMERGENCIES

IF YOU SEE THIS	***DO THIS***

IF AN EMERGENCY OCCURS:

1. If the emergency is life-threatening, immediately call 911.
2. Stay with student or designate another adult to do so.
3. Call or designate someone to call the principal and/or school nurse.
   a. State who you are.
   b. State where you are.
   c. State problem.

DOCUMENTATION OF STAFF TRAINING

DATE:	**TRAINED BY:**	**STAFF NAME:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

STUDENTS TRANSPORTED WITH SPECIAL EQUIPMENT/NEEDS
DRIVER/ATTENDANT INFORMATION SHEET

STUDENT NAME : _____SCHOOL:_____
ADDRESS:_____TEACHER: _____

PARENT/GUARDIAN:_____ AM ROUTE:____PM ROUTE:____

HOME PHONE #:_____ WORK #:_____ CELL #:_____

EMERGENCY CONTACT:_____ PHONE:_____ OTHER PHONE:_____

PHYSICIAN:_____ PHYSICIAN TEL:_____ PHYSICIAN FAX:_____

SPECIAL EQUIPMENT OR MEDICAL NEEDS ON BUS

I.E. OXYGEN TANK, WHEELCHAIR, SEIZURES, GO-BAGS, ETC.- PLEASE INCLUDE SIZE AND DIMENSIONS OF ALL EQUIPMENT

EMERGENCY BUS PLAN

IF YOU SEE THIS	*DO THIS*

BEHAVIOR PLAN

BEHAVIOR OR DISABILITY:_____

INTERVENTION TO MANAGE THE BEHAVIOR/DISABILITY

OTHER SPECIFIC NEEDS FOR SAFELY TRANSPORTING STUDENT

DOCUMENTATION OF DRIVER/ATTENDANT TRAINING

DATE	DRIVER/ATTENDANT NAME	NURSE/SCHOOL OFFICIAL