**Seizure Careplan**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_ Age when diagnosed\_\_\_\_\_\_\_\_­­­\_\_\_\_

Parent/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of seizure does child have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do the seizures occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has it been since his/her last seizure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does he/she experience an aura before having a seizure? \_\_\_\_\_\_\_ If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| |  |  |  |  | | --- | --- | --- | --- | | MEDICATION NAME | DOSE/ AMOUNT TAKEN | HOW OFTEN? | WILL MEDICATION BE NEEDED  AT SCHOOL? | |  |  |  |  | |  |  |  |  | |

Dose student have a Vagus Nerve Stimulator (VNS)? \_\_\_\_\_\_\_\_\_ Where is magnet worn? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe use of the magnet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SIGNS OF SEIZURES**: PLEASE CHECK BEHAVIORS THAT APPLY TO YOUR CHILD. | | | | |
| SIMPLE  SEIZURES | GENERALIZED  SEIZURES | | **DANGER SIGNS-**  **CALL 911** | BEHAVIORS EXPECTED  AFTER SEIZURE |
| □ Lip smacking  □ Behavioral outbursts  □ Staring  □ Twitching  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ Sudden cry or squeal  □ Falling down  □ Rigidity/Stiffness  □Thrashing/Jerking  □ Loss of bowel/bladder control  □ Shallow breathing  □ Stops breathing  □ Blue color to lips  □ Froth from mouth  □ Gurgling or grunting noises  □ Loss of consciousness  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * + - * Seizure lasts more than 5 minutes * Another seizure starts right after   the 1st seizure   * Loss of consciousness * Stops breathing * If student has diabetes * If seizure is the result of an   injury or child is injured during  seizure   * If student is pregnant * If student has never had a seizure   before | * Tiredness * Weakness * Sleeping, difficult to arouse * Somewhat confused * Regular breathing * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   **ALL OF ABOVE CAN LAST A FEW**  **MINUTES TO A FEW HOURS.** |
| **IF YOU SEE THIS** | | **DO THIS** | | | |
| SEIZURE ACTIVITY | | Stay calm. Move surrounding objects to avoid injury. Do not hold the student down or put anything  in the mouth. Loosen clothing as able. After seizure stops, roll student on his/her side**. Document**  **seizure activity on back of this form.** If applicable, administer medications as ordered. Notify the parent/guardian. | | | |
| STOPS BREATHING | | Begin CPR/Rescue breathing. Call 911 | | | |
| LOSS OF BOWEL OR BLADDER  CONTROL | | Cover with blanket or jacket. If necessary: discreetly assist with changing of clothes after seizure. | | | |
| DANGER SIGNS-SEE ABOVE | | Call 911. Then call parent/guardian. | | | |
| FALLS DOWN,  LOSS OF CONSCIOUSNESS | | Help student to the floor for observation and safety | | | |
| VOMITING | | Turn on side | | | |

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| **SIGNATURES** | DATE | PARENT SIGNATURE | NURSE SIGNATURE | GRADE/TEACHER |
| PLAN INITIATED |  |  |  |  |
| 1ST REVIEW |  |  |  |  |
| 2ND REVIEW |  |  |  |  |

Emergency Action Plan for Seizure Disorder Continued

Student’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Call emergency medical services (911) and tell them “a student is having a seizure” if:**

* Seizure last longer than \_\_\_\_ minutes.
* Child has \_\_\_\_ seizures in \_\_\_\_ minutes.
* Child has any injury during a seizure.

|  |  |
| --- | --- |
| **Rescue Therapy** |  |
| * **Use Vagal Nerve Stimulator Magnet:** |  |
| **Diastat** (diazepam rectal gel) | **\_\_\_mg rectally as needed for a seizure lasting more than \_\_\_\_ minutes** |
| * **Tranxene** | \_\_\_**mg by mouth when awake enough to swallow. Prevent more seizures** |
| * **Valium** | **\_\_\_mg by mouth when awake enough to swallow. Prevent more seizures.** |
| * **Ativan** | **\_\_\_mg by mouth when awake enough to swallow. Prevent more seizures** |

**Actions after a Seizure:**

* **Permit Child to rest in Health Office**
* **Provide a Change of clothing as needed**
* **Permit Child to Return to Class**
* **Contact Parent/Guardian**
* **Provide a note or copy of seizure record to Parent/Guardian**

My signature below is an acknowledgment that I understand that the District, its Board of Directors, and its employees shall be immune from civil liability for injury resulting from the administration of medications to the student named above.

As Parent/Guardian I have reviewed this Care Plan for my child and agree with its contents. I also agree that this information may be shared with the Principal, Teachers and staff for awareness and preparedness in providing the best care for my child. I also agree to notify the school if any changes occur such as, change in medication, physicians or treatment. I agree that the school nurse may contact the physician named in this care plan to discuss this care plan.

Physician Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_