

SEIZURE CARE PLAN AND MEDICATION ORDERS Plan ___ of ___

NAME		Birthdate:	School		
Grade	Preferred Hospital	<input type="checkbox"/> Bus #	<input type="checkbox"/> Walk	<input type="checkbox"/> 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 entire body.	Staring spells. May drop an object s(he) is holding or may stumble momentarily.	Some degree of impairment of consciousness-- may have automatic movements like lip smacking, roaming, and non-goal oriented activity.
Comments	Comments	Comments
*IDENTIFY students usual signs/symptoms	*IDENTIFY students usual signs/symptoms	*IDENTIFY students usual signs/symptoms

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

➤ Child does not start waking up within _____minutes after 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

Name:
Primary #
Other #
Other #



Name:
Primary #
Other #
Other #

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Accommodations needed ____ No ____ Yes If yes, list below:

- A new EAP and medication/treatment orders 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 employees to 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

- | | |
|--|--|
| <ul style="list-style-type: none"> ◆ Tiredness ◆ Weakness ◆ Sleeping ◆ Difficult to arouse ◆ May be somewhat confused | <ul style="list-style-type: none"> ◆ 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 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)				