SEIZURE EMERGENCY ACTION PLAN/504—NO MEDICATION

NAME:		**Birthdate:**	**Teacher:**	
Grade:	**Preferred Hospital:**	☐ **Bus #**	☐ **Walk** ☐**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. **Comments:**	Staring spells. May drop an object s(he) is holding or may stumble momentarily. **Comments:**	Some degree of impairment of consciousness-- may have automatic movements like lip smacking, roaming, and non-goal oriented activity. **Comments:**
****BOLD students usual signs/symptoms**	****BOLD students usual signs/symptoms**	****BOLD students usual signs/symptoms**

IF YOU SEE THIS	DO THIS Adult stays with student at all times
ABSENCE AND PYSCHOMOTOR 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 and ease student to floor to avoid a fall. 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 or is first tonic clonic seizure.
- 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).**

THERE ARE NO MEDICATIONS ORDERED

LHP Signature	Date:	Telephone: Fax Number:
LHP Printed Name	Start Date:	End Date:

(If applicable)

Document seizure activity on Seizure Observation Log (attached)

7/22/21

PARENT/GUARDIAN SECTION

Parent/Guardian

Name:
Home Phone:
Work Phone:
Other:

Name:
Home Phone:
Work Phone:
Other:

ADDITIONAL EMERGENCY CONTACTS:

1.	Relationship:	Phone:
2.	Relationship:	Phone:

****Does the student need classroom, school activity, or recess accommodations? _____ Yes _____ No**

- A new Seizure Emergency Action Plan (EAP) for seizures must be submitted each school year.
- I understand that 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 911 staff, if they are called.
- I have reviewed the information on this Seizure Emergency Action Plan/504 and request/authorize trained school employees to provide this care in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- 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 treatment orders.*

Parent/Guardian Signature Date

EXPECTED
POST-SEIZURE BEHAVIOR

- Tiredness
- Weakness
- Sleeping
- Difficult to arouse
- May be somewhat confused
- Regular breathing
- This period may last a few minutes or hours

For District Nurse's Use Only

A registered nurse has completed a nursing assessment and developed this Seizure Emergency Action/504 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)				