Emergency Action Plan: Seizures

Student Name: _____ DOB: _____ School Year: _____

Teacher/Classroom: _____ Grade: _____ € Emergency Medication Available

Emergency Contact Information		
Parent/Guardian:	Relationship:	Phone:
Parent/Guardian	Relationship	Phone:
Physician:	Phone:	Fax:

Seizure Information			
Seizure Type	Length	Frequency	Description
Seizure triggers or warning signs?			
Routine seizure medication/dose/route/times:			

Seizure Action Plan

If you see this:	Do this:	Emergency Seizure Protocol	Expected behavior following a seizure:
· Sudden cry or squeal · Falling down · Rigidity/stiffness · Thrashing/jerking · Loss of bowel/bladder control · Shallow breathing · Blue color to lips · Froth from mouth · Gurgling/grunting · Loss of consciousness · Staring · Lip smacking · Eye rolling · Other: _____ · Other: _____ · Other: _____	**BASIC SEIZURE FIRST AID** · Stay calm and track time · Call for assistance · Keep child safe · Do not restrain · Place child on side, turn head to side · Remove nearby objects · Remove glasses, tight clothing · Do not place anything in mouth · Keep airway open · Monitor breathing – be prepared to start CPR · Stay with child until conscious · Do not give food or fluids during or immediately after a seizure · Call parent	€ Call 911 at _____ minutes for transport to ER € Call parent or emergency contact € Administer **EMERGENCY MEDICATION** as directed: _____ _____ € Other: _____ € Other: _____ **A SEIZURE IS CONSIDERED AN EMERGENCY WHEN:** · **Convulsive (tonic-clonic) seizure lasts longer than 5 minutes** · **Student has repeated seizures with or without regaining consciousness** · **Student is injured, pregnant, diabetic, has a head injury, high fever, or is poisoned** · **Student has a first-time seizure (no history of seizures)** · **Student has breathing difficulties** · **Slow recovery or difficult to arouse after a seizure** · **Student has a seizure in the water**	· Tiredness · Weakness · Sleeping · Difficult to arouse · Confused · Regular breathing · Other: _____ **Follow-Up** · Notify School Nurse · Document event · Call parent if not already done · Student to go home if Emergency Medication was administered

Emergency Medication			
Medication	Dose	Physician/Label Instructions	Med. Location

· As the parent/guardian of the above-named student, I give my permission for my child's healthcare provider to share information with the School Nurse for the completion of this EAP. I understand the information contained in this order will be shared with the school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student's health status, healthcare needs, or medical order. Initial: _____

· If medication is ordered, I authorize school staff to administer medication (described above) to my child. If prescription is changed, a new "Physician's Authorization for Medication at School" form must be completed before the school staff can administer the medication. Initial: _____

· Parents/guardians are responsible for maintaining necessary supplies, medications, and equipment. Initial: _____

Parent Signature: _____ Initials: _____ Date: _____