Date Plan Developed: ____
School nurse : xt 2334

WELLPINIT SCHOOL DISTRICT

SEIZURE
Emergency Care Plan

STUDENT'S NAME			Weight:
School	Grade		Birth date
Doctor:	Phone #:	Fax:	Preferred Hospital:
Transportation ☐ Walk ☐ Car ☐ Bus #			
Physical Education – Days and Time or Period:			
Medications taken at home:			
Brief History:			

TYPES of SEIZURES

Grand Mal *(Also known as Tonic-Clonic)*	**Petit Mal** *(Also known as Absence Seizures)*	**Psychomotor** *(Arise from the frontal or temporal regions of the brain)*
Muscles tense, body rigid, followed by a temporary loss of consciousness and violent shaking of entire body. Comments: Usually lasts ______ minutes ***Student's usual signs/symptoms**	Staring spells. May drop an object s(he) is holding or may stumble momentarily. Comments: ***Student's usual signs/symptoms**	Some degree of impairment of consciousness, may or may not be accompanied by automatic movements like lip smacking, roaming, and **non-goal oriented activity.** Comments: ***Student's usual signs/symptoms**

IF YOU SEE THIS	**DO THIS** **Adult stays with student at all times**
PETIT MAL and PSYCHOMOTOR SEIZURE:	Time Seizure and Monitor student closely. Notify the Nurse and Parent. No first aid is needed if no injury. Record (and Describe Seizure Activity on reverse).
GRAND MAL or TONIC CLONIC SEIZURE ACTIVITY (for vomiting –turn on side) (for loss of bowel/bladder cover with blanket for privacy)	1. Stay calm & Ease student to floor to avoid a fall. 2. Clear area around student-move hard objects. Keep others away. 3. Loosen clothing around neck. Place soft material under head. **Do not hold student down.** **Do not put anything in the mouth.** 4. CALL THE NURSE & PARENTS 5. Start a written record of the seizure behavior & treatment including length of seizure activity.

CALL 911 IF:

- Seizure does not stop by itself
- Seizure does not stop within _______minutes
- Another seizure starts immediately after the first seizure
- Child does not start waking up within _______minutes after seizure is over
- Bluish color to lips AFTER seizure ends
- Loss of consciousness
- Stops breathing

Describe seizure or complete seizure log (see reverse)
Note time of arrival and departure of ambulance; complete this form, initial, and send a copy of form with the ambulance.

PARENT/GUARDIAN SECTION

EMERGENCY CONTACTS

Mother/Guardian	
Name	
Home Phone	
Work Phone	
Other	

Father/Guardian	
Name	
Home Phone	
Work Phone	
Other	

ADDITIONAL EMERGENCY CONTACTS

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

- A new Emergency Care Plan (ECP) for Seizures must be submitted each school year.
- I understand that if any changes are needed on the ECP, it is the parent's responsibility to contact the school nurse.
- It is the parent's responsibility to alert all other school programs of their child's health condition. Such as sports/field trips, ect.
- Medical information may be shared with school staff working with your child and 911 staff, if they are called
- *My signature below shows I have reviewed and agree with this Emergency Care Plan*

Parent/Guardian Signature ______________________ Date

THIS SECTION BELOW TO BE FILLED BY THE SCHOOL NURSE

School Nurse: ______________ Phone: ______________ Cell Phone: ______________

The following school staff are trained regarding this care plan

1. ______________ Date: _____ 2. ______________ Date: _____ 3. ______________ Date: _____

4. ______________ Date: _____ 5. ______________ Date: _____ 6. ______________ Date: _____

Seizure Activity Log

Date	Time	Duration	Description	Action	Initials

EXPECTED AFTER SEIZURE BEHAVIOR

- Tiredness
- Weakness
- Sleeping, difficult to arouse
- May be somewhat confused
- Regular breathing
- Can last a few minutes or hours
- May be somewhat confused

Reviewed by School Nurse (Signature) ______________________ Date

Health Plan and Medication (if prescribed) must accompany student on any field trip or school activity.

*****Keep plan readily available for Substitutes.*****

Attention Bus Drivers: To Activate Emergency Procedures-Pull Over, Call Dispatch to Call 911

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

WELLPINIT SCHOOL DISTRICT CARE PLAN FOR SEIZURE MANAGEMENT

PHYSICIAN'S ORDER FOR SEIZURE MANAGEMENT

Student's Name: ______________________ Birthdate: ______________

School: __________________________ Grade: ______________Teacher: __________________

Weight_________________

TO BE COMPLETED BY THE PHYSICIAN

TYPE OF SEIZURE(S) student experiences: ____

DESCRIPTION of seizure presentation for this student: ____

____

PE Modifications/Special Instructions (swimming, rock climbing, heights, etc.): __________________

____

If Student has a seizure described above, initiate the following procedure(s):

☐ No emergency medication required. Follow basic seizure first aid.

☐ Student has VNS. Instructions for VNS magnet use: ____

VNS= (vagal nerve stimulation)

☐ Give emergency medication below for a seizure that lasts longer than ______ minutes.

☐ Give emergency medication below for a cluster of seizures that lasts longer than ______minutes.

☐ Other: ____

Seizure Medication: _________________________ Dosage: ________________ Route: ___________________

Frequency: ______________________________ Side Effects: _______________________________________

Duration of Order: __Current School Year___ or other: (specify duration) _________________________

X____

PHYSICIAN/LICENSED PRESCRIBER'S SIGNATURE PRINTED NAME DATE

OFFICE PHONE NUMBER: ____________________________ OFFICE FAX NUMBER: ___________________________

PARENT/GUARDIAN AUTHORIZATION FOR SCHOOL MEDICATION

I hereby request that Wellpinit school district employees administer or supervise the administration of medication in accordance with the routine described under the Guidelines for the Administration of Medication in Wellpinit School District. **I understand that I will need to pick up unused doses of the medication at the end of the school year. Unused medication will not be sent home with my child and will be destroyed if not picked up by the last day of school.**

I hereby release Wellpinit School District and any of its agents, employees administrators or other parties (hereinafter, the "District") from any liability for any injury or harm which is suffered by (student's name) ______________________________ as a result of our District's agreement to honor this request. I agree to indemnify and hold the District harmless from any legal action or other attempts to acquire compensation, including damages and legal and medical fees, from the District whenever the District has acted in accordance with the information provided by my child's physician and by the Guidelines for the Administration of Medication in Wellpinit School District.

PARENT/GUARDIAN SIGNATURE: ____ DATE: _______________________

Please return this form with your child's medication to the school health office.

Revised 6/2016

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Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Contact Information

Student's Name	School Year	Date of Birth	
School	Grade	Classroom	
Parent/Guardian	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	Location	
Significant Medical History or Conditions			

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? ____________________
2. Seizure type(s)

Seizure Type	Length	Frequency	Description

3. What might trigger a seizure in your child? ____________________
4. Are there any warnings and/or behavior changes before the seizure occurs? ❐ YES ❐ NO
   If YES, please explain: ____________________
5. When was your child's last seizure? ____________________
6. Has there been any recent change in your child's seizure patterns? ❐ YES ❐ NO
   If YES, please explain: ____________________
7. How does your child react after a seizure is over? ____________________
8. How do other illnesses affect your child's seizure control? ____________________

Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? ❐ YES ❐ NO
    If YES, what process would you recommend for returning your child to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? ❒ YES ❒ NO
    If YES, please explain:

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Seizure Medication and Treatment Information

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and Time of Day Taken	Possible Side Effects

14. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to Do After Administration

** After 2nd or 3rd seizure, for cluster of seizure, etc.* *** Orally, under tongue, rectally, etc.*

15. What medication(s) will your child need to take during school hours? ______
16. Should any of these medications be administered in a special way? ❒ YES ❒ NO
    If YES, please explain: ______
17. Should any particular reaction be watched for? ❒ YES ❒ NO
    If YES, please explain: ______
18. What should be done when your child misses a dose? ______
19. Should the school have backup medication available to give your child for missed dose? ❒ YES ❒ NO
20. Do you wish to be called before backup medication is given for a missed dose? ❒ YES ❒ NO
21. Does your child have a Vagus Nerve Stimulator? ❒ YES ❒ NO
    If YES, please describe instructions for appropriate magnet use:

Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

❒ General health ______
❒ Physical functioning ______
❒ Learning ______
❒ Behavior ______
❒ Mood/coping ______
❒ Physical education (gym/sports) ______
❒ Recess ______
❒ Field trips ______
❒ Bus transportation ______
❒ Other ______

General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? ______

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ❒ YES ❒ NO

Dates ______
Updated ______
______

Parent/Guardian Signature ______ **Date** ______

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