

Seizure Emergency Care Plan and Medication Orders for School and Childcare Settings

PARENT/GUARDIAN complete and sign the top portion of form.		Place child's photo here
Child Name:	Birth date:	
Parent/Guardian Contact:	Phone:	
Emergency Contact:	Phone:	
School:	Grade:	
Triggers: <input type="checkbox"/> tiredness <input type="checkbox"/> flashing lights <input type="checkbox"/> illness <input type="checkbox"/> hunger <input type="checkbox"/> temperature <input type="checkbox"/> Other: _____ Seizure Aura (if any): _____ Seizure history: <input type="checkbox"/> Convulsive <input type="checkbox"/> Focal <input type="checkbox"/> Absence Date of last known seizure _____ Describe: _____		
Antiseizure Medication Taken at Home	Common side effects	
Other Seizure Treatments/Special Diet Therapy:		

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and devices. I approve this Seizure Emergency Care Plan for my child.

_____ PARENT SIGNATURE _____ DATE _____ SCHOOL NURSE SIGNATURE _____ DATE 504 plan
 IEP

HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.

IF YOU SEE THIS:	DO THIS:
<input type="checkbox"/> Convulsive Generalized Tonic Clonic: You will see loss of consciousness. Stiffening of the body. Rhythmic jerking movements. Convulsive seizures may last 1-5 minutes. The child may have a warning (aura) before the seizure. Sleepiness and confusion may occur after the seizure.	1. Time the seizure 2. Keep calm. Provide reassurance. 3. Protect head, keep airway clear, turn on side if possible. 4. Do not place anything in mouth. 5. Call 911 if student is injured or has difficulty breathing. 6. Call parent. 7. Stay with student until recovered from seizure. 8. Administer rescue treatments as marked below.
<input type="checkbox"/> Focal: These seizures may begin with an aura. They may be partly alert or unconscious. You may see lip smacking, chewing, eye blinking, or picking at clothes. These seizures usually last 1-2 minutes.	1. Time the seizure 2. Gently guide child away from danger. 3. Stay with student and reassure them until recovered from seizure. 4. Do not treat staring that is stopped by a touch or a nudge. 5. Call parent. 6. Administer rescue treatments as marked below.
<input type="checkbox"/> Absence: You will see quick changes in alertness. May see eye flutter or small twitching. Usually last less than 10 seconds.	

Rescue Treatments <input type="checkbox"/> Child has a VNS. Child/staff may swipe with aura. Staff may swipe at onset of seizure and every 60 seconds until seizure stops. Give rescue medications below if seizure does not stop within _____ minutes. If seizure <u>lasts longer</u> than ___ minutes administer: <div style="border: 1px solid black; padding: 2px; display: flex; justify-content: space-between;"> <input type="checkbox"/> Diastat ___mg rectally <input type="checkbox"/> Midazolam ___mg in the nose <input type="checkbox"/> Clonazepam ___mg in the cheek </div> <input type="checkbox"/> Multistep seizure rescue plan – Please see attached letter for details. If <u>cluster</u> of ___ or more seizures in _____ min administer: <div style="border: 1px solid black; padding: 2px; display: flex; justify-content: space-between;"> <input type="checkbox"/> Diastat ___mg rectally <input type="checkbox"/> Midazolam ___mg in the nose <input type="checkbox"/> Clonazepam ___mg in the cheek </div> <input type="checkbox"/> Multistep seizure rescue plan – Please see attached letter for details. If emergency medication is administered: <input type="checkbox"/> Call 911 immediately or <input type="checkbox"/> Call 911 if seizure does not stop within 5 minutes Other: _____ If no emergency medication is at school and the child is experiencing seizures: Call family to bring medications to school or pick up child. Call EMS if seizure lasts more than ___ min

Accommodations: Always take seizure action plan and emergency medication for school activities, sports and field trips. Close adult supervision when swimming or climbing.

_____ HEALTH CARE PROVIDER SIGNATURE _____ PRINT PROVIDER'S NAME _____ PHONE/FAX _____ DATE