

Winfield R-IV School District Seizure Action Plan

Emergency Care Plan

**Place
Student's
Picture
Here**

TO BE COMPLETED BY PARENT

Student _____ D.O.B. _____ Teacher/Grade _____
 Treating Healthcare Provider _____ Phone _____ Fax _____
 Seizure triggers or warning signs _____
 Student's reaction to seizure _____

TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY

List Known Medical Conditions, Medications & Allergies: _____

SEIZURE TYPE	LENGTH	FREQUENCY	DESCRIPTION	LAST SEIZURE DATE

BASIC FIRST AID: CARE AND COMFORT
(Please describe basic first aid procedures)

EMERGENCY RESPONSE A seizure emergency for this student is defined as:

<p>1. If you see this:</p> <p>Blank staring with an inability to focus or speak</p>		<p>1. Do this:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Note the time the behavior begins <input type="checkbox"/> Call for school nurse or trained personnel <input type="checkbox"/> Allow rest if needed <input type="checkbox"/> Other: _____ 		
<p>2. If you see this:</p> <p>Twitching or jerking of localized area of body and/or muscle tension of localized area of body</p>		<p>2. Do this:</p> <table style="width: 100%;"> <tr> <td style="vertical-align: top;"> <ul style="list-style-type: none"> <input type="checkbox"/> Note the time the behavior begins <input type="checkbox"/> Clear objects from surrounding area <input type="checkbox"/> If they appear unsteady place them on the floor on their left side <input type="checkbox"/> Loosen any tight clothing from neck </td> <td style="vertical-align: top;"> <ul style="list-style-type: none"> <input type="checkbox"/> Call for school nurse or trained personnel <input type="checkbox"/> If lasts longer than _____ minutes, trained personnel to give _____ <input type="checkbox"/> Allow rest if needed <input type="checkbox"/> Other: _____ </td> </tr> </table>	<ul style="list-style-type: none"> <input type="checkbox"/> Note the time the behavior begins <input type="checkbox"/> Clear objects from surrounding area <input type="checkbox"/> If they appear unsteady place them on the floor on their left side <input type="checkbox"/> Loosen any tight clothing from neck 	<ul style="list-style-type: none"> <input type="checkbox"/> Call for school nurse or trained personnel <input type="checkbox"/> If lasts longer than _____ minutes, trained personnel to give _____ <input type="checkbox"/> Allow rest if needed <input type="checkbox"/> Other: _____
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<p>3. If you see this:</p> <p>(may have 1 or more of the following)</p> <ul style="list-style-type: none"> • Twitching or jerking of the entire body • muscle tension of entire body • loss of bladder/bowel control • shallow breathing or temporary suspended breathing (bluish skin) 		<p>3. Do this:</p> <table style="width: 100%;"> <tr> <td style="vertical-align: top;"> <ul style="list-style-type: none"> <input type="checkbox"/> Note the time the behavior begins <input type="checkbox"/> Contact school nurse or trained personnel <input type="checkbox"/> Clear objects from surrounding area <input type="checkbox"/> Place them on the floor on their left side </td> <td style="vertical-align: top;"> <ul style="list-style-type: none"> <input type="checkbox"/> Loosen any tight clothing from neck <input type="checkbox"/> If lasts longer than _____ minutes, trained personnel to give _____ <input type="checkbox"/> Notify parent or emergency contact <input type="checkbox"/> Call 911 for transport _____ <input type="checkbox"/> Other _____ </td> </tr> </table>	<ul style="list-style-type: none"> <input type="checkbox"/> Note the time the behavior begins <input type="checkbox"/> Contact school nurse or trained personnel <input type="checkbox"/> Clear objects from surrounding area <input type="checkbox"/> Place them on the floor on their left side 	<ul style="list-style-type: none"> <input type="checkbox"/> Loosen any tight clothing from neck <input type="checkbox"/> If lasts longer than _____ minutes, trained personnel to give _____ <input type="checkbox"/> Notify parent or emergency contact <input type="checkbox"/> Call 911 for transport _____ <input type="checkbox"/> Other _____
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During a seizure do **NOT** put anything in the person's mouth and do **NOT** hold the person down or try to stop their movement.

- Does student need any special activity adaptations/protective equipment (e.g., helmet) at school? YES NO
 (Explain) _____
- Is student allowed to participate in physical education and other activities? YES NO
 (Explain) _____

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)	
Daily / As Needed Medication	Dosage and Time

Physician/Healthcare Provider (Print) _____ Physician/Healthcare Provider (Signature) _____ Date _____ Phone number _____

TURN FORM OVER

The Permission for Medication Administration Form must be completed in addition to the Seizure Action Plan if medication is required at school.

Basic Seizure First Aid

- ✓ Stay calm and track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Other _____

For tonic-clonic (grand mal) seizure:

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

A Seizure is generally considered an Emergency when:

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

 <p>1. Put person on their left side where they can't fall</p>	 <p>2. Get medicine and take out syringe. <i>Note: Seal pin is attached to cap</i></p>	 <p>3. Push up with thumb and pull to remove cap from syringe. <i>Note: Be sure seal pin is removed with the cap.</i></p>
 <p>4. Lubricate rectal tip lubricating jelly</p>	 <p>5. Bend upper leg forward and separate buttocks to expose rectum</p>	 <p>6. Gently insert syringe tip into rectum. <i>Note: Rim should be snug against rectal opening</i></p>
 <p>7. Slowly count to 3 while gently pushing plunger in until it stops</p>	 <p>8. Hold buttocks together to prevent leakage</p>	 <p>9. Keep person on their side facing you, note time given</p>

EMERGENCY INFORMATION

Student Name: _____
 Parent Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____
 Alt. Phone Number: _____

EMERGENCY CONTACTS

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

Parent/Guardian Authorization and Permission for Release of Information

1. I give permission for the above information to be shared in confidence with appropriate staff and emergency personnel. In the event of an emergency, I authorize school personnel to obtain emergency medical care and/or emergency transportation by ambulance to the hospital.
2. I give permission for the school nurse to contact my child's health care provider to obtain any medical information pertaining to my child's seizure condition.
3. I request that the above medication(s) be sent on field trips.
4. I agree with the above Seizure Action Plan and give permission for the medication(s) to be given by school personnel as delegated, trained, and supervised by the school nurse.

Parent/Guardian (Print) _____ Parent/Guardian (Signature) _____ Date _____

FOR SCHOOL PERSONNEL ONLY

- ❖ Medication authorization complete YES NO For: _____
- ❖ Medication maintained in nurse office YES NO For: _____
- ❖ Medication self-carried YES NO For: _____
- ❖ Copies of Action Plan provided to:
 - Teacher(s) YES NO
 - Principal's Office YES NO
 - Athletic YES NO
 - Food Service YES NO
 - Other _____ YES NO
- ❖ Staff trained in medication administration YES NO

 School Personnel (Print) School Personnel (Signature) Date

 School Personnel (Print) School Personnel (Signature) Date

 School Personnel (Print) School Personnel (Signature) Date

FULL SEIZURE PLAN HAS BEEN IMPLEMENTED

 Nurse Signature Nurse Signature Date