

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

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

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.

\_\_\_\_\_  504 plan  
 PARENT SIGNATURE                      DATE                      SCHOOL NURSE SIGNATURE                      DATE                       IEP

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

IF YOU SEE THIS:	DO THIS:
<input type="checkbox"/> <b>Convulsive Generalized Tonic Clonic:</b> 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. <b>Administer rescue treatments as marked below.</b>
<input type="checkbox"/> <b>Focal:</b> 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. <b>Administer rescue treatments as marked below.</b>
<input type="checkbox"/> <b>Absence:</b> You will see quick changes in alertness. May see eye flutter or small twitching. Usually last less than 10 seconds.	

**Rescue Treatments**

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 lasts longer than \_\_\_ minutes administer:

<input type="checkbox"/> Diastat ___mg rectally	<input type="checkbox"/> Midazolam ___mg in the nose	<input type="checkbox"/> Clonazepam ___mg in the cheek
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Multistep seizure rescue plan – Please see attached letter for details.

If cluster of \_\_\_ or more seizures in \_\_\_\_\_ min administer:

<input type="checkbox"/> Diastat ___mg rectally	<input type="checkbox"/> Midazolam ___mg in the nose	<input type="checkbox"/> Clonazepam ___mg in the cheek
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Multistep seizure rescue plan – Please see attached letter for details.

**If emergency medication is administered:**  Call 911 immediately or  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