SEIZURE EMERGENCY ACTION PLAN/504--VERSED OR DIASTAT

Place student picture here

Date plan created: _____ **Date plan revised:** _____

NAME:		**Birthdate:**	**Teacher:**
Grade:	**School:**	☐ **Bus #**	☐ **Walk** ☐ **Drive**
Doctor:	**Phone:**	**Fax:**	**Preferred Hospital:**

History (including current medication):

TYPES of SEIZURES		
Tonic Clonic	**Absence**	**Psychomotor**
Muscles tense, body rigid, followed by a temporary loss of consciousness and violent shaking of entire body. Comments:	Staring spells. May drop an object s(he) is holding or may stumble momentarily. Comments:	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:

IF YOU SEE THIS	DO THIS **Adult stays with student at all times**
ABSENCE AND PYSCHOMOTOR SEIZURES:	Time seizure and monitor student closely. Notify the nurse _____ and parent _____. Gently support and protect student from harm. Do not restrain. No first aid is needed if no injury. After seizure, calmly reorient student to his surroundings. Record seizure activity on Seizure Observation Log.
TONIC CLONIC SEIZURE ACTIVITY **<u>Do not hold student down. Do not put anything in their mouth.</u>** (for loss of bowel/bladder cover with blanket for privacy)	Time Seizure Activity. After seizure record events on the Seizure Observation Log. Stay calm & ease student to floor to avoid a fall. Administered medications as ordered below. Clear area around student-move hard objects. Keep others away. Support student on his left side to allow vomit/drool to drain. Loosen clothing around neck. Place soft material under head. NOTIFY THE NURSE _____ & PARENT _____.

CALL 911 IF:

- Seizure does not stop by itself or is first tonic clonic seizure
- Seizure does not stop within _____minutes
- Child does not start waking up within _____minutes after seizure is over
- Another seizure starts immediately after the first seizure
- Bluish color to lips AFTER seizure ends
- Prolonged loss of consciousness
- Stops breathing **(START RESCUE BREATHING/CPR)**

- **VERSED** (Midazolam intra-nasal spray) _____ mg intra-nasal prn *OR* **DIASTAT** (rectal diazepam) _____ mg for:
  Seizure > _____ minutes OR for _____ or more seizures in _____ hours
- Child does not start waking up within _____ minutes after seizure is over

Document seizure activity on Seizure Observation Log (attached).

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

(Spokane Public Schools Health Services revised 5/20)

PARENT/GUARDIAN SECTION

EMERGENCY CONTACTS

Name	
Home Phone	
Work Phone	
Other	

Name	
Home Phone	
Work Phone	
Other	

ADDITIONAL EMERGENCY CONTACTS:

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

****Does the student need classroom, school activity, or recess accommodations? ___yes ___no. If yes, please contact the school counselor.**

- A new health care plan for seizures must be submitted each school year.
- I understand that if any changes are needed on the HCP, it is the parent's responsibility to contact the school nurse.
- It is the parent's responsibility to alert all other non-school programs of their child's health condition.
- Medical information may be shared with school staff working with your child and 911 staff, if they are called.
- I have reviewed the information on this health care plan and medication order and request/authorize trained school employees to provide this care and administer this medication in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- I understand this is a life-threatening plan and can only be discontinued by the LHP.
- I authorize the exchange of information about my child's seizure disorder between the LHP office and the school nurse.
- *My signature below shows I have reviewed and agree with this health care plan.*

Parent/Guardian Signature Date

EXPECTED POST-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

For District Nurse's Use Only

This plan has been reviewed/approved by the School District Nurse.

Medication/Device(s) Expiration date(s):

School Nurse Signature **Date** **Phone:**

Health care plan and medication (if prescribed) must accompany student on any field trip or school activity.

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

(Spokane Public Schools Health Services revised 5/20)

Date & Time				
Seizure Length				
Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)				
Conscious (yes/no/altered)				
Injuries (briefly describe)				
Muscle tone/body movements	Rigid/clenching			
	Limp			
	Fell down			
	Rocking			
	Wandering around			
	Whole body jerking			
Extremity movements	(R) arm jerking			
	(L) arm jerking			
	(R) leg jerking			
	(L) leg jerking			
	Random Movement			
Color	Bluish			
	Pale			
	Flushed			
Eyes	Pupils dilated			
	Turned (R or L)			
	Rolled up			
	Staring or blinking (clarify)			
	Closed			
Mouth	Salivating			
	Chewing			
	Lip smacking			
Verbal Sounds (gagging, talking, throat clearing, etc.)				
Breathing (normal, labored, stopped, noisy, etc.)				
Incontinent (urine or feces)				
Post-seizure observation	Confused			
	Sleepy/tired			
	Headache			
	Speech slurring			
	Other			
Length to Orientation				
Parents Notified? (time of call)				
9-1-1 Called? (call time & arrival time)				
Observer's Name				

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