Seizure Action Plan

Student: _____ DOB: _____ Teacher/Grade: _____

PARTIAL: May not lose consciousness, but may have a change of consciousness and be dazed, confused, and unaware of where they are or what they are doing and will not remember what they have experienced; can experience a range of symptoms such as: sudden jerky movement of one part of the body or weakness such as arm or leg; sudden fear; facial movements; disturbances of vision, hearing, or smell; nausea, vomiting, or stomach discomfort. May exhibit chewing or repetitive arm and hand movement. They may wonder around randomly, mumble, and behave in unusual ways; may be sleepy/tired afterwards.

TONIC-CLONIC (GRAND MAL): Loss of consciousness, child falls to floor or ground, breathing may stop for a moment, arms and legs may become rigid and move in rhythm with face, may be incontinent of urine and/or feces, may last several minutes, may want to sleep afterwards.

ABSENCE (PETIT MAL): Brief loss of consciousness, minimal or not alteration in muscle tone, usually able to maintain postural control, frequently has minor movements or twitching, often mistaken for inattention.

INTERVENTIONS:

1. Stay with child during and after seizure. Note duration of seizure and type of body movement during seizure episode.
2. Assist to horizontal position if loss of consciousness occurs. Remove glasses, loosen clothing around neck
3. Turn on side as soon as able to prevent choking.
4. Clear area around child to prevent injury.
5. **DO NOT RESTRAIN MOVEMENT OR PLACE ANYTHING IN MOUTH.**
6. Monitor breathing and begin artificial respiration if breathing does not resume spontaneously.
7. If seizure lasts more than 5 minutes or child has one seizure after another without waking, call 911
8. **When seizure is over, allow child to rest and always notify parents. DO NOT offer food or water until chil is fully awake.**
9. ADDITIONAL INSTUCTIONS: _____

Medications at Home: □ None

Name	Dose	Route	Times Administered

Medications at School: □ None (If medications are needed at school a Physician's signature is required.)

Name	Dose	Route	Times to be Administered

Side effects/reactions: _____

Contraindications for Administration: _____

Vagal Nerve Stimulator: □ No □ Yes Stimulator site:_____ Magnet kept:_____

Directions: _____

DIASTAT Acudial (Diazepam Rectal Gel) □ 5 mg □ 7.5 mg □ 10 mg □ 12.5 mg □ 15 mg □17.5 mg □ 20 mg for **seizure longer than 5 minutes**

Physician's Signature _____ Date: _____
Print/Stamp physician name, address and phone number:

Seizure Action Plan (con't)

Student: _____ DOB: _____

School: _____ Teacher/Grade: _____

SEIZURE HISTORY

1. What type of seizures does your child have and how often do they occur? _____
2. Describe your child's symptoms during and after the seizure episode. _____

_____

3. Does your child have an aura or warning of seizure coming? □ YES □ NO
4. Is he/she able to notify anyone that a seizure is coming? □ YES □ NO
5. Are there any sports/activities in which your child CANNOT fully participate? _____
6. What steps do you want school personnel to take if a seizure should happen? _____

_____

All medication for use at school will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

Parent Permission

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release Neuse Charter School Board of Director and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for the year, unless revoked.

I give permission to designated staff members of Neuse Charter School to perform and carry out the tasks as outlined by this Seizure Action Plan. I also consent to the release of the information contained in this Seizure Action Plan to all staff members and other adults who have custodial care of my child and who need to know this information in order to maintain my child's health and safety.

Acknowledged and received by:

Parent/Guardian _____ Date _____

Parent Email address _____ Parent Phone Numbers_____

EMERGENCY CONTACTS: Name/Relation

1._____a) home_____ b) work _____ c) cell_____

2._____a) home_____ b) work _____ c) cell_____

3._____a) home_____ b) work _____ c) cell_____

Principal's Signature _____ Date _____

School First Responder's Signature _____ Date _____