Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: | Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ■ Yes ■ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

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

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ■ Contact school nurse at ____________________
- ■ Call 911 for transport to ____________________
- ■ Notify parent or emergency contact
- ■ Administer emergency medications as indicated below
- ■ Notify doctor
- ■ Other ____________________

A seizure is generally considered an emergency when:

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

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ■ Yes ■ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature ____________________ **Date** ____________________

Parent/Guardian Signature ____________________ **Date** ____________________

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LACORDAIRE ACADEMY

Rectal Diastat/ Intranasal Midazolam Consent Form

Student's Name____ **D.O.B.** ________________________

Parent/Guardian's Name__________________________________ **Date** ___________________________

Telephone: Cell____________________ **Work**________________ **Home** _________________________

PART 1- To be completed by student's Primary Healthcare Provider (MD, DO, APN) or Neurologist

A. MEDICATION ORDER:

I certify that it is essential to the health of ___________________________________ that the following medication be administered by the school nurse during school hours as directed. This student will not be able to attend school or school sponsored events without this medication.

Diagnosis: ______________________________Date of Last Documented Seizure: __________________

Name of Medication: _____________________________________Dosage: _______________________

Mode of Administration: __________ Frequency of Administration: _____________________________

Date of Last Documented Seizure: ________________

Date of Last Administration of Diastat/Midazolam: ____

Side Effects of Medication: ____

Length of Time Order is Valid (may not exceed school year):_____________________________________

______ **MEDICATION MAY BE OMITTED ON A CLASS TRIP**

Signature and Stamp of Primary Healthcare Provider (MD, DO, APN) or Neurologist:

____ **PHONE#** _________________________________

PART 2- To be completed by student's Parent/Guardian

Parent/Guardian Permission for School Nurse/Substitute School Nurse Administration of Medication

I give permission for the school nurse to administer the medication described on the reverse side. I will notify the nurse immediately if this medication is no longer required. I disclaim all liability of Lacordaire Academy as it concerns the use of this medication.

I further understand that this permission is effective only for the school year for which it is granted.

All medication must be delivered to the school nurse by the parent/guardian.

All medication must be in the original pharmacy-labeled container with the prescription affixed or it will not be administered by the school nurse.

Any unused medication must be picked up by the student's parent/guardian. Medication not picked up by the last day of school will be discarded.

Parent/Guardian Name (please print) ____

Parent/Guardian Signature _______________________________ **Date:** ________________________ Rev 12/2019