SEIZURE ACTION CARE PLAN

HS1 1.5c

Child's Name: _____ **Date of Birth** _____/_____/_____

Parent /Guardian:_____

Emergency Phone Numbers: Parent/Guardian: _____If no answer call: _____ *(See emergency contact information for alternate contacts if parents are unavailable)*

Primary Health Care Provider: _____

Phone #:_____

To be completed by Healthcare Provider/ Physician

SEIZURE INFORMATION:

Date of Last Known Seizure	*Seizure Type*	*Description* **(length/frequency/details)**

Seizure triggers or warning signs:_____

Student's reaction to seizure: _____

Current medications: _____

EMERGENCY RESPONSE:

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

_____

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

- ☐ Administer emergency medications as indicated below
- ☐ Notify parent or emergency contact
- ☐ Notify Doctor
- ☐ Other _____
- ☐ Comments _____

***Call 911 for transport if:**

- ☐ Respiratory distress (describe)_____
- ☐ Seizure lasting **longer than** _____ minutes.
- ☐ Student has repetitive seizures.
- ☐ **If Diastat is given it is recommended that student is either transported via ambulance to hospital or released to parents for close monitoring.**

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
- Record seizure in log

For tonic-clonic (grand mal) seizures:

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

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

TREATMENT PROTOCOL DURING SCHOOL HOURS:

(include Emergency AND Daily Medications)

Will student require Emergency Medication or other prescribed Seizure Medication at School? ☐ YES ☐ NO

Medications	*Dose (MUST match prescription label)*	*Side Effects & Instructions*
DIASTAT: ☐ YES ☐ NO	Administer ____mg of RECTAL DIASTAT AFTER ____minutes of Seizure Activity	
Treatment/Medication prior to Diastat:		
Treatment/Medication prior to Diastat:		

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Child's Name: _____ **Date of Birth** _____/_____/_____

This medication is required to be available on the bus: ☐ **YES** ☐ **NO**

Does Student have a **Vagus Nerve Stimulator (VNS)?** ☐ **YES** ☐ **NO**

If YES, describe magnet use: _____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS:

(regarding school activities, sports, trips, transportation, etc.)

_____

_____

COMMENTS: _____

_____

_____

_____

Healthcare Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state and federal laws and regulations.

PHYSICIAN Signature _____ Date _____

To be completed by Parent or Guardian

I have developed this health plan in partnership with my child's healthcare provider and Head Start staff. I will communicate any changes in my child's identified health condition or treatment to Head Start staff as changes occur.

Effective _____**Expires** _____

This plan will be reviewed and updated annually.

As the parent/legal guardian of _____(Child's Name), I _____(Parent/Guardian Name) give my Permission for OVEC Staff to administer the Emergency Action Plan including the administration of Medication as stated in this plan and post information under the classroom Health Alert. I further release OVEC and its employees from any claims or liability connected with its reliance on this permission.

Parent/Guardian (print name) _____

Parent/Guardian Signature _____ Date: _____

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To be completed by Staff after being trained

Child's Name: _____ Date of Birth _____/_____/_____

By signature, staff acknowledges education by parent or guardian on condition(s) and requirement of emergency care and/or medication if needed.

(All staff in center must be trained):

Staff Signature _____ Date: _____

Staff Signature _____ Date: _____

Staff Signature _____ Date: _____

Staff Signature _____ Date: _____

Staff Signature _____Date: _____