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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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. 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: _____