THE MASTER'S ACADEMY

Individual Health Care Plan

Seizure Plan of Action

Student:_____ Grade:_____ Date:_____

1. If student is having a convulsive seizure, gently TURN HIM ON HIS SIDE, cushion head.
2. Make note of the time seizure activity began and call the school nurse to your location.
3. DO NOT PUT ANYTHING IN THE MOUTH or hold the tongue. The student cannot swallow his/her tongue. Putting objects in mouth can cause injury.
4. DO NOT RESTRAIN THE STUDENT unless there is a threat of physical harm. Loosen tight clothing is necessary. (There is no ability to apply logic during times of altered consciousness. Sight, sound and pain are not registered.)
5. DO NOT GIVE ANYTHING BY MOUTH during the seizure or immediately afterwards.
6. SPEAK CALMLY and reassuringly until seizure passes. Never assume student heard or understood instructions you gave.
7. STAY WITH THE STUDENT until consciousness returns and student is able to say who he is, where he is and what day it is. If student begins to walk away from the given setting, accompany the student until responses are appropriate.
8. If seizure lasts longer than 5 minutes, unless otherwise specified below, 911 will be called.
9. Allow student to rest as needed when consciousness returns.
10. There is no re-call of events that occur during seizure activity. Accurate documentation of the event should be completed and made part of student's file.
11. Maintain the student's privacy during and seizure activity and recovery period as much as possible.

If medication and/or Vagus Nerve Stimulator is necessary, the physician must complete the appropriate form in detail.

Additional physician's orders:

Additional parents comments:

Physician Signature:_____ Date:_____

Parent Signature:_____ Date:_____

School Nurse Signature_____ Date:_____

Seizure
Individual Health Care Plan

Date:_____

Student: _____ DOB: _____ Grade:___

Parent/Guardian_____Phone:_____

Physician:_____Phone:_____

Other Emergency Contact:_____ Phone:_____

Allergies: _____ Age when seizure activity began:_____

Date of student's last seizure: _____ Frequency of Occurrence: _____

Has student been hospitalized for seizures? If yes, when? _____

Has seizure ever lasted longer than 5 minutes? [ ] Yes [ ]No If yes, what intervention was needed?_____

Seizure Medications: Name Dose Time

_____

_____

Other Medications: _____

_____

Side Effects: _____

Limitations to Activity? [ ] Yes [ ] No *If Yes, please be specific and attach physcian's order._____

Other Considerations?_____

_____

_____

INDIVIDUAL HEALTH CARE PLAN

SEIZURE DESCRIPTION

Student Name _____ Date _____

1. **Type of seizures:** π Convulsive (generalized, tonic-clonic, grand mal) π Complex partial π Absence (petit-mal) π Psychomotor π Other _____

2. **Prior to a seizure does your child experience a warning?** ❒ Yes ❒ No

   If yes, describe it: _____

   _____

3. **Please list anything that seems to trigger a seizure:** _____

   _____

4. **Check the events seen DURING a seizure:**

   ❒ Eyes turned up and fixed left
   ❒ Eyes turned up and fixed right
   ❒ Head turned and fixed left
   ❒ Head turned and fixed right
   ❒ Loss of consciousness
   ❒ Stiffening on left side
   ❒ Stiffening on right side
   ❒ Stiffening on both sides
   ❒ Jerking on left side
   ❒ Jerking on right side
   ❒ Jerking on both sides
   ❒ Becomes pale
   ❒ Becomes flushed
   ❒ Turns blue
   ❒ Stops breathing
   ❒ Lip smacking/chewing
   ❒ Picking movements
   ❒ Impaired speech
   ❒ Falls
   ❒ Cries out
   ❒ Unresponsiveness
   ❒ Confusion or disorientation
   ❒ Drooling
   ❒ Blinks eyes
   ❒ Staring
   ❒ Loss of bowel control
   ❒ Loss of bladder control
   ❒ Bites tongue
   ❒ Walks around
   ❒ Confusion or disorientation. How long? _____
   ❒ Other _____

5. **Check the things you see FOLLOWING the seizure**

   ❒ Confusion or disorientation. How Long? _____
   ❒ Complains of headache
   ❒ Nausea
   ❒ Complains of weakness
   ❒ Other _____
   ❒ Complains of body aches
   ❒ Vomits
   ❒ Sleeps How long? _____

Medical History & Physician Prescribed Emergency Seizure Treatment Order

(To Be Completed by Child's Physician)

History

Child's Name _____ Age _____ Weight_____

Seizure Types _____ Description _____

Allergies _____ Treatment Order Date _____

Treatment Order:

- Rescue medication _____ mg rectally prn for:
  seizure > _____ minutes OR for _____ or more seizures in _____ hours
- Use VNS (vagal nerve stimulator) magnet _____
- Other _____
- Call 911 if:
  - Seizure does not stop by itself or with VNS within _____ minutes
  - Seizure does not stop within _____ minutes of administering rescue medication
  - Child does not start to wake up within _____ minutes after seizure is over (no rescue medication given)
  - Child does not start to wake up within _____ minutes after seizure is over (after rescue medication given)

- Following a seizure: (Please check off)

☐ Child should rest in nurse's office

☐ Child may return to class

☐ Parents/Caregiver should be notified immediately

☐ Parents/caregiver should recieve a copy of the seizure record sent home with the child

Physician Information:

Physician/Nurse Practitioner/Physician Assistant Name (Printed)_____

Signature_____ Date _____

License Number_____ State _____

Address _____

Phone Number_____ Fax_____

Developed in collaboration with Christine O'Dell, RN, MSN and Shlomo Shinnar, MD, PhD, of the Comprehensive Epilepsy Management Center, Montefiore Medical Center, Bronx, New York.

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