WONEWOC-CENTER SCHOOLS SEIZURE ACTION PLAN

Student's Name:_____ **Date of Birth:**_____
Parent/Guardian Name(s):_____ **Phone:** _____
School Attending:_____ **Grade:**_____ **School Year:**_____
Practitioner:_____ **Practitioner Phone:**_____

☐ Seizures are no longer an issue for my child. (Please sign and return Action Plan)

Significant medical history/summary:

_____

_____

_____

SEIZURE INFORMATION: When was your child diagnosed with seizures or epilepsy?_____

Seizure Type	*Length*	*Frequency*	*Description*

Date of last Seizure_____
Seizure triggers or warning signs:_____
Student's reaction to seizure:_____

BASIC FIRST AID: CARE & COMFORT: *(Please describe additional 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:

_____

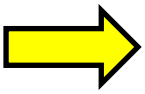
Basic Seizure First Aid:
- ✓ Stay calm & track time seizure started
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure type & time in log

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

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

_____

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



ACTION:

CALL 911

- ✓ Stay with the student until help arrives
- ✓ Call parent/guardian AND school nurse
- ✓ Administer emergency medication as listed below
- ✓ CPR if needed, get AED and use if needed per training

MEDICATIONS/DOSES:

- ☐ Administer Diastat rectal gel for seizure lasting longer than ____ minutes.
  Dose_____
  Other: _____

- ☐ Administer _____ for seizure lasting longer than ____ minutes.
  Dose_____
  Other: _____

CALL 911 IF: (please check and complete)

- ☐ Seizure does not stop by itself in ____ minutes
- ☐ Anytime medication is given
- ☐ Only if seizure does not stop in ____ minutes after giving medication
- ☐ Other:_____
  _____

Continued on back

PARENT/GUARDIAN CONSENT:

- I request and authorize that this medication be administered by school personnel.
- I understand that medication may be given by non-medically trained school personnel.
- I will supply medication in its original, updated, properly labeled container. (Request extra bottle from pharmacist.)
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- I further understand that all medication should be delivered to the school by parent/guardian.
- I will pick up unused medications at the end of the school year. Unclaimed medications will be discarded.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.

_____ _____

Signature of Parent/Legal Guardian Date

PHYSICIAN ORDER:

The above medication is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication and understand the medication may be given by non-medically trained school personnel. Please contact me if the following symptoms occur:

_____

_____ _____ _____

Physician Printed Name Address Phone

_____ _____

Signature of Physician Date