New Albany-Floyd County Consolidated School Corporation
Health Services
2023-2024 School Year

Attach child's photo

Seizure Action Plan

Child's name: _____ **School:** _____
Teacher: _____ **Grade:**_____ **Date of birth:** ____/____/_____ **Age:**_____
Parent/Guardian: _____ **Phone:** _____
Treating Physician: _____ **Phone:** _____ **Fax:** _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____
Name of Med/Rx _____ How much to give (dose) _____
How to give _____

If seizure (cluster, # or length) _____
Name of Med/Rx _____ How much to give (dose) _____
How to give _____

_____ _____ _____ _____
***Parent/Guardian Authorization Signature** **Date** **Physician/HCP Authorization Sign.** **Date**

_____ _____
***Parent/Guardian Printed Name** **Physician/HCP Printed Name**

Seizure Action Plan page 2

Child's name: _____

Seizure Action Plan *continued*

Care after seizure

What type of help is needed? (describe) _____

When is student able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

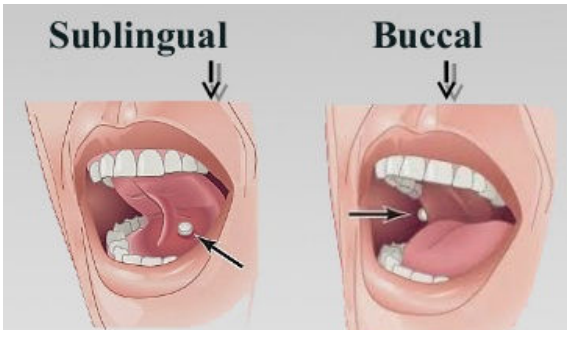
Seizure Action Plan page 3
Child's name: _____

*Parent/Guardian, please note:

By signing page 1, I give permission to the School Nurse and other trained personnel members to perform the tasks as outlined in the Seizure Action Plan. I understand that a School Nurse is not always present at my child's school and I give consent for other trained school personnel to provide care to my child as needed according to this plan. I give permission for the School Nurse and prescribing health care provider to exchange information regarding any necessary medication order clarifications, response to medication, and adverse effects. I also consent to the release of information contained in this Seizure Action Plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. Unless other arrangements are made, I give the school permission to send home medication that has been in its possession with my child at the end of the school year.

General Seizure First Aid

Buccal/Sublingual Medication Administration



VNS Directions

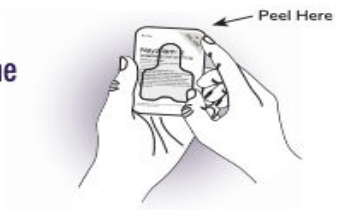
1 Respond
Always carry the magnet with you so you are ready to respond.

2 Pass (move)
Pass (move) the magnet over the generator for **less than** two seconds.

Nayzilam Administration Instructions

1 Peel

When ready to use, open the blister packaging. Hold blister packaging in the palm of your hand.
On the foil backing, find the "Peel Here" tab and pull down.



Remove the device carefully.

2 Hold

Hold the device with your thumb on the plunger and your middle and index fingers on each side of the nozzle.

DO NOT PRESS the plunger yet.

3 Place

Place the tip of the nozzle into one nostril until your fingers are against the bottom of the patient's nose.

4 Press

Press the plunger firmly.

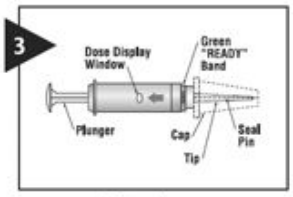
5 Dispose

Throw away (dispose of) the device and blister packaging in a common trash bin.

Diastat Administration Instructions

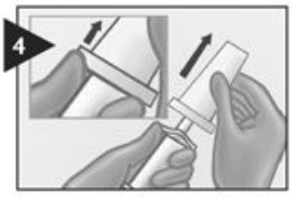
Put person on their side where they can't fall.

Get medicine.



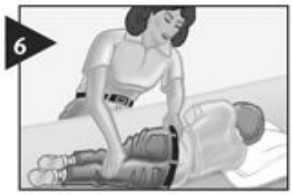
Get syringe.

Note: Seal Pin is attached to the cap.

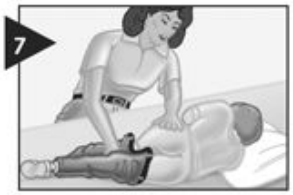


Push up with thumb and pull to remove cap from syringe. **Be sure Seal Pin is removed with the cap.**

Lubricate rectal tip with lubricating jelly.



Turn person on side facing you.



Bend upper leg forward to expose rectum.

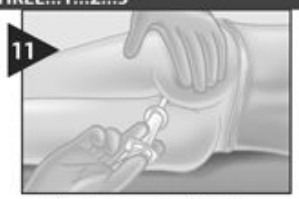
Separate buttocks to expose rectum.

Gently insert syringe tip into rectum.

Note: Rim should be snug against rectal opening.

SLOWLY COUNT OUT LOUD TO THREE...1...2...3

Slowly count to 3 while gently pushing plunger in until it stops.



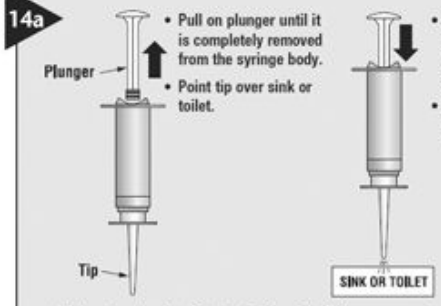
Slowly count to 3 before removing syringe from rectum.

Slowly count to 3 while holding buttocks together to prevent leakage.

ONCE DIASTAT® IS GIVEN

Keep person on side facing you, note time given and continue to observe.

DISPOSAL INSTRUCTIONS FOR DIASTAT ACUDIAL



This step is for Diastat® AcuDial™ users only

At the completion of step 14a:

- Discard all used materials in the garbage can.
- Do not reuse.
- Discard in a safe place away from children.

DISPOSAL FOR DIASTAT 2.5 MG

14b

At the completion of step 13:

- Discard all used materials in the garbage can.
- Do not reuse.
- Discard in a safe place away from children.

Student Name:

Date & Time					
Seizure Length					
Pre-Seizure Aura, Behavior, Trigger					
Responsive (Y/N)					
Any Injuries					
Muscle Tone/Body Movements	**Rigid/clenching**				
	Limp				
	Fell down				
	Rocking				
	Wandering around				
	Whole body jerking				
Extremity Movement	**Right arm jerking**				
	Left arm jerking				
	Right leg jerking				
	Left leg jerking				
	Random movement				
Skin Color	**Bluish**				
	Pale				
	Flushed				
Eyes	**Pupils large**				
	Turned (R or L)				
	Rolled up				
	Staring or blinking				
	Closed				
Mouth	**Salivating**				
	Chewing				
	Lip smacking				
Verbal Sounds (gag, throat clear)					
Breathing (normal, noisy, stopped)					
Incontinent (urine or feces)					
After Seizure Observations (confused, tired, speech slurred)					
Parents Notified? (time of call)					
EMS Called? (time of call/arrival)					
Observer's Name					

For School Personnel:

Please note:

- **If 911 is called and a student is transported to the hospital, NAFCS staff must accompany the student in the ambulance unless parent and/or emergency contact accompanies them.**
- **Document event and any medications given. Give used emergency medication to EMS.**
- **Ensure assistive personnel notifies ASC if a 911 call is made.**
- **If prescribed medical treatment is not available to school personnel, call EMS for any signs/symptoms noted on page 1 that require calling 911. Contact the School Nurse.**
- **Please ensure rescue medication is taken on all field trips.**
- **Be sure to share this information with any substitute teacher.**

Personnel who are trained including the date of training:	Location of supplies:
1. _____ Date _____ 2. _____ Date _____ 3. _____ Date _____ 4. _____ Date _____ 5. _____ Date _____ 6. _____ Date _____ 7. _____ Date _____ 8. _____ Date _____ 9. _____ Date _____ 10. _____ Date _____	☐ Health office ☐ With student_____ ☐ Classroom ☐ Specials classrooms ☐ Bus ☐ Other _____

This plan has been reviewed and approved by:	Copies of HCAP given to/Date given:
_____ School Nurse's Signature Date _____ Building Principal's Signature Date	Health Office _____ Teacher (Elem)_____ Principal_____ TOR (Sped) _____ Cafeteria_____ IEP(Sped) _____ ESC (Sped)_____ Bus/Aide_____ Transportation (if med in backpack for use on bus)_____ All trained staff_____