Seizure Action Plan(7-16)

Student's Name:_____DOB: _____ School/Teacher_____

Parent/Guardian: _____ Phone (w): _____ (c): _____ (h): _____
Parent/Guardian: _____ Phone (w): _____ (c): _____ (h): _____
Physician: _____ Phone:_____ Fax: _____

SEIZURE INFORMATION			
Seizure Type	Length	Frequency	Description

Seizure Triggers or warning signs:	Response after seizure:
Special Considerations and Precautions: (activities, trips…)	**Dietary Adjustments due to medication: (Complete Diet Order if needed)**
Medications:	

TREATMENT	
☐ **Absence** ☐ **Atonic** ☐ **Complex Partial** ☐ **Infantile Spasms**	1. Stay with the student during and after the seizure. Although the student may appear conscious, he/she may lose awareness of surroundings. 2. Be prepared to assist student to the floor if he loses consciousness. 3. Time seizures and watch for clusters. 4. Document seizure in log. 5. Notify parent:☐(Notebook) ☐(phone) ☐(email) ☐(text) **Special Instructions:**
☐ **General Tonic/Clonic**	1. Do not restrain movement. Assist student to floor if possible. Remove hard, sharp objects from the area 2. Turn student on side in recovery position. Loosen the student's collar. Do not place anything in the mouth. Protect student's privacy. 3. Observe, note time, and be prepared to describe the pattern of the seizure. 4. Record details as they occur or as soon as possible thereafter. 5. Notify parent :☐(Notebook) ☐(phone) ☐(email) ☐(text) 6. When seizure is over, allow the student to rest. 7. Stay with the student until fully recovered or parent arrives.
Administer Emergency Medication:	**Diastat Order:** _____ **Vagus Nerve Stimulator?** ☐ Yes ☐ No If **Yes**, Location of VNS: _____ Swipe after _____min. Repeat Swipe if: _____(Please include max number of times to swipe)
Call 911! 	**Call 911** if: • The seizure lasts more than _____ minutes, or • The student has a continuous seizure, or cluster of ≥ ____seizure(s) • The student remains unconscious after the seizure, or • He or she is having difficulty breathing, or • Any injury resulted from the seizure, especially head injuries. • _____

❖ **Physician's signature:** _____ Date: _____

Medications require HCPS Medication Administration Form. Special procedures require MD signature.

I hereby authorize my physician/medical provider to release to the school nurse specific, confidential medical information contained in his/her record about my child. This information will be used by school staff to deliver health care services to my child in school.

Parent / Guardian Signature: _____ Date: _____
School Nurse Signature: _____ Date: _____

Student's Name: _____ Date:_____

Teaching Log for Vagus Nerve Stimulator (VNS)

****please check off each item covered****

The teaching session should include:

- ***How a vagus nerve stimulator works to stop a seizure.***
- ***Signs and symptoms of seizure activity in this student.***
- ***At what point in seizure activity is the VNS used.***
- ***Number of times magnet should be swiped (according to physician's order)***
- ***Locations of VNS in chest wall***
- ***Location of VNS magnetic wand***

Description of Procedure for VNS Administrations

_____***Observe child for seizure activity***

_____***Time seizure***

_____ ***Activate VNS by moving the magnetic wand across vagus nerve stimulator according to physician's order***

_____***Call 911 for seizure lasting longer than 5 minutes (or according to Physician's order), respiratory distress or unresponsiveness following seizure.***

_____ ***Notify parent***

Nurse Instructor Name: _____

Staff Sign In:

Name	***Signature***	***Date***
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____