Jackson Local Schools

SEIZURE ACTION PLAN

Student's Name: ______________________________ DOB: ____________________

Grade: ________ Teacher: ______________________________ School Year: ____________________

Date of last seizure: _________ Does your child have emergency medication (i.e. Diastat) at school? ☐ Yes ☐ No

What does a **"typical"** seizure look like and how long does it last? ______________________________

____

♦BASIC FIRST AID FOR SEIZURES♦

Most seizures end without harm after 1 or 2 minutes.

1. Remain calm
2. Note the time that the seizure began
3. Stay with the student
4. Remove other students from classroom
5. Have office notify the school nurse and parent
6. Lay student on their side, cushioning head
7. Loosen tight clothing
8. Move objects out of the way that may cause injury
9. **DO NOT** put anything in the student's mouth
10. **DO NOT** attempt to restrain the student
11. Note the time the seizure ended
12. Call School Nurse

After the seizure:

- The child may need to be cleaned up if he/she vomited or soiled their clothes
- The child may appear sleepy or complain of a headache.
- Escort child to clinic to rest and for observation

♦SEIZURE EMERGENCY RESPONSE♦

A seizure is generally considered an emergency when:

- A convulsive seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has difficulty breathing
- This is a **first-time** seizure for the student

♦SEIZURE PROTOCOL FOR THIS STUDENT♦

(this section must be completed by the treating physician)

Treatment:

- ☐ Diastat (diazepam rectal gel) ______________mg rectally PRN for seizures:
  lasting > ___ 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 giving Diastat
- ☐ Child does not start waking up within _______ minutes after seizure is over
- ☐ Child stops breathing or turns blue
- ☐ Other ____

Following a Seizure:

- ☐ Child should rest in office/clinic area ________ minutes
- ☐ Child may return to class immediately
- ☐ Parents/caregiver should be notified immediately
- ☐ Other ____

I give permission to the school nurse and other designated staff members of Jackson Local Schools to perform the health management tasks as outlined by this Individualized Health Plan. I also consent to the release of the information contained in this plan to all staff members who have custodial care of my child and may need to know this information to maintain my child's health and safety while at school and extracurricular activities.

Parent/Guardian Signature: ______________________________ Date: ______________

Physician Signature/Phone: ______________________________ Date: ______________

Jackson Local Schools
SEIZURE LOG

Student's Name: ______________________________ DOB: ____________________

Grade: ________ Teacher: ______________________________ School Year: ____________________

Date of Seizure: ____________________ Time Seizure Started: ___________ Time Seizure Ended: _________

Length of Seizure:___________min ___________ sec Location of Seizure: ________________

Pre-seizure activity: (Describe behaviors, possible triggering events, and activities prior to seizure):

____

____

Seizure Activity Checklist

Check all that apply

Consciousness
- ☐ Change in awareness
- ☐ Loss of ability to communicate
- ☐ Complaints of aura
- ☐ Confusion
- ☐ Not responsive to name
- ☐ Slurred speech
- ☐ Complaint of headache

Muscle Tone/Movements
- ☐ Typical for student
- ☐ Rigid/clenching/stiffening
- ☐ Limp
- ☐ Rocking
- ☐ Wandering around
- ☐ Whole body jerking
- ☐ Fell to ground

Extremity Movements
- ☐ None
- ☐ Right arm jerking/twitching
- ☐ Left arm jerking/twitching
- ☐ Right leg jerking/twitching
- ☐ Left leg jerking/twitching
- ☐ Random movement

Color
- ☐ Typical for student
- ☐ Pale
- ☐ Flushed
- ☐ Dusky
- ☐ Blue

Eyes
- ☐ Open
- ☐ Closed
- ☐ Pupils dilated
- ☐ Rolled upward
- ☐ Turned to right/left (circle one)
- ☐ Fixed stare
- ☐ Blinking

Mouth
- ☐ Salivating
- ☐ Chewing
- ☐ Lip Smacking
- ☐ Drooling

Verbal Sounds
- ☐ Talking
- ☐ Gagging
- ☐ Throat clearing
- ☐ Gurgling

Breathing
- ☐ Normal
- ☐ Labored
- ☐ Noisy
- ☐ Rapid

Release of Body Fluids
- ☐ None
- ☐ Urine
- ☐ Feces
- ☐ Vomit

Potential Injuries
- ☐ None
- ☐ Sudden fall
- ☐ Struck desk
- ☐ Hit floor

Other (describe)

Post-Seizure Observation
- ☐ Confused
- ☐ Sleepy/Tired
- ☐ Headache
- ☐ Slurred Speech
- ☐ Other (describe)

Response to Seizure Checklist

Check all that apply

Treatment
- ☐ Anti-seizure medication administered (time: __________________)
- ☐ School Nurse Notified (time: ______________________)
- ☐ Parents Notified (time: __________________)
- ☐ EMS Called (time: ______________________)

Post-Seizure Action
- ☐ Rested in clinic (________ minutes)
- ☐ Transported home by parent
- ☐ Transported to hospital by parent
- ☐ Transported to hospital by EMS
- ☐ Copy of seizure log given to parents
- ☐ Copy of seizure log given to EMS

Observer's Signature: ______________________________ Date: ________________

Principal's Signature: ______________________________ Date: ________________

School Nurse's Signature: ______________________________ Date: ________________