Northwest Allen County Schools

SEIZURE CARE PLAN Parent and Physician Information School Year:_____-_____

PARENT INFORMATION

Student _____ Grade _____ D.O.B. _____ Teacher _____
Parent/Legal Guardian Name: _____ Daytime Phone: _____ Cell: _____
Emergency Phone Contact #1: _____ Relationship: _____ Daytime Phone: _____ Cell: _____
Emergency Phone Contact #2: _____ Relationship: _____ Daytime Phone: _____ Cell: _____
_____
Family Doctor: _____ Telephone: _____ Neurologist: _____ Telephone: _____

Hospital Preference ❒ Lutheran (W. Jefferson) ❒ Lutheran (Dupont) ❒ Parkview (PRMC) ❒ Parkview (Randallia) ❒ Lutheran (downtown)

Identify the things that may trigger a seizure in your child -Check all that apply
☐ Exercise ☐Stress ☐Fatigue ☐Heat ❒Other_____

Seizure History
Age when seizures began _____ Date of last doctor's appointment for seizures _____ Date of last seizure _____

Type of Seizure
❒ Absence ❒ Tonic-clonic ❒ Atonic/Tonic drop ❒ Myoclonic ❒ Focal aware ❒ Focal impaired awareness ❒ **Aura** (Prior to Seizure) ___ Yes ___ No

Describe Usual Symptoms: _____

Emergency Care
School staff will call 911 for the following circumstances: absences of breathing or pulse, seizure lasting longer than 5 minutes or a seizure that persists beyond 5 minutes after special medications or procedures have been started, two or more seizures without a period of consciousness >5 minutes between, continued pale or bluish skin lips, or noisy breathing after the seizure stops. Other _____

Daily Medications taken to control Seizures

Medication Name	Amount	When Used (Time)
1.		
2.		

Emergency Medications or Measures ***Note: these will need physician authorization for use at school***

Medication Name	Amount	When Used (Time)	Has your child ever received this medication?
1.			❒ yes ❒ no
2.			❒ yes ❒ no

Note: If school nurse is not available Diastat/Versed/Valtoco may be administered by trained unlicensed staff in the school setting. Diastat cannot be administered on a school bus. Bus drivers will dispatch EMS for care.

I agree that this information (plan) may be shared with the appropriate staff members, who work with the student, on a need-to-know basis. I hereby release Northwest Allen County Schools and any of its agents, employees, administrators, from any liability for any injury or harm which is suffered by my child as a result of our District's agreement to honor the above request. I agree to allow the school nurse to contact my physician about my child's treatment plan for school. I agree to keep the school nurse updated in writing about my child's health and contact the school nurse in writing if any changes are made in the plan.

_____ _____
Parent Signature **Date**

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PHYSICIAN INFORMATION *This section is only to be filled out by the health care provider and is only necessary for the special circumstances listed below.*

Student _____ DOB _____

Seizure Care

☐Student may remain at school after a seizure if the seizure is < _____ and recovery time is < _____

☐Use Diastat®(diazepam rectal gel) _____ mg rectally PRN for:
- ☐ Seizure greater than _____ minutes **AND/ OR**
- ☐ for _____ or more seizures in _____ hours.

☐ Use Versed/Valtoco (circle) _____ mg nasally for:
- ☐ Seizure greater than _____ minutes **AND/ OR**
- ☐ for _____ or more seizures in _____ hours.

☐Use Vagal Nerve Stimulator (VNS) Magnet

Position of VNS (Please Indicate)

1. Assist student to a safe position with head to the side (to keep airway open)
2. Locate the implanted generator in the _____ chest.
3. Swipe the magnet over the implant, moving from **bottom to top,** to the count of 1-2-3. (This can be done over clothing)
4. Swipe again if the seizure continues for more than one minute. Continue to swipe once each minute until seizure activity ceases.

☐ **Other _____**

Activity Restrictions

☐ Helmet needed ☐Recess ☐ Gym/Sports ☐ Swimming ☐ Field Trips ☐Other _____

Details of restrictions _____

CALL 911 if

- ❑ Seizure does not stop by itself within _____ minutes.
- ❑ Two or more seizures **without** a period of consciousness between, which last 5 minutes or greater.
- ❑ Continued unusually pale or bluish skin/lips or noisy breathing after the seizure has stopped.
- ❑ Seizure does not stop with **VNS** within _____ minutes.
- ❑ Seizure does not stop within _____ minutes of giving Diastat/ Versed/Valtoco
- ❑ Child does not start waking up within _____ minutes after seizure is over (when **no emergency med is given**).
- ❑ Child does not start waking up within _____ minutes after seizure is over (**AFTER** Diastat/Versed/Valtoco given).

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Physician Signature_____ Date_____