EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: | Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe 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
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

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

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at ____________________
- ❒ Call 911 for transport to ____________________
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other ____________________

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature ____________________ **Date** ____________

Parent/Guardian Signature ____________________ **Date** ____________

DPC772

Insert child's picture here

DIASTAT® AcuDial™ (diazepam rectal gel) Plan-at-a-Glance

Seizure Preparedness Plan

Seizure Information

Name ______________________________

Date of birth ______________________________

Current medication(s) ______________________________

Allergies ______________________________

Seizure type(s) ______________________________

Frequency of seizures ______________________________

Description ______________________________

Seizure usually lasts __________minutes

Usually recover in __________minutes

Please notify:

Family ______________________________

Home Phone __________________ Cell __________________

Physician __________________ Phone __________________

Parent Signature ____________________ Date ___/___/___

First Aid Steps

for Convulsions or Seizures

- Cushion head, remove glasses
- Loosen tight clothing
- Turn on side and keep airway clear
- Note the time a seizure starts and the length of time it lasts
- Don't put anything in mouth
- Don't hold down
- As seizure ends, offer help

If I am injured or unconscious for more than 5 minutes please

call 911

- **Treatment**
  - Administer DIASTAT® (diazepam rectal gel) _____ mg

  for seizure >_____ minutes or for _____ or more seizures in _____ hours
  - Use VNS 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

    Student does not start waking up within ___ minutes after seizure is over (no DIASTAT given)

    Student does not start waking up within ___ minutes after seizure is over (after DIASTAT given)

  Other ______________________________

Following a seizure:

Child should rest in nurse's office

Child may return to class

Parents/caregiver should be notified immediately

Parents/caregiver should receive a copy of the seizure record sent home with the child

Developed in collaboration with Christine O'Dell, RN, MSN, and Shlomo Shinnar,MD,PhD, of the Comprehensive Epilepsy Management Center, Montefiore Medical Center, Bronx, New York.

Asthma Action Plan / Medication Authorization Form

for all children with asthma

Student Name ______________________ **Student ID #** ______________

School Year ______________ **Grade** ________ **Teacher** ______________________

Parent/Guardian ______________________ **Home #** ________ **Cell #** ________ **Work #** ________

Physician's Name ______________________ **Phone #** ____________ **Fax #** ____________

* * * * * * * * * * * * * * * *

1. **NO SMOKING in your home or car, even if your child is not with you!**
2. Always use a spacer with inhalers (MDIs)
3. Shake inhaler before every spray (puff).
4. Remove, control and stay away from known triggers in your child's environment.
5. Clean plastic part of inhaler weekly using package directions.
6. Prime inhaler after opening and before use if not used in more than two weeks. (Pro-Air: 3 puffs; all others – 4 puffs.)

Child's triggers are: *(check all that apply)*

- ☐ Cockroaches
- ☐ Dust, dust mites
- ☐ Exercise
- ☐ Household cleaners
- ☐ Indoor/outdoor pollution
- ☐ Indoor pets
- ☐ Mold
- ☐ Pollen
- ☐ Respiratory infections or flu
- ☐ Smoke
- ☐ Strong emotion
- ☐ Strong odors or sprays
- ☐ Weather/temperature changes
- ☐ Other allergies ______________

____

____

____

____

GREEN ZONE - ALL CLEAR - GO!!!	**USE CONTROLLER MEDICINES**

ASTHMA IS WELL CONTROLLED

You should have:
- No wheezing
- No coughing
- No chest tightness
- No waking up at night because of asthma
- No problems with play because of asthma

Peak flow number from _____ **to** _____

☐ No controller medicine needed at this time

Medicine	**Method**	**How much**	**How often**
________	________	________	______ **times per day**
________	________	________	______ **times per day**
________	________	________	______ **times per day**
________	________	________	______ **times per day**

15 minutes before exercise use _______ puffs (inhaled)

*Rinse child's mouth after using inhaled steroids (daily/controller medicines)

YELLOW ZONE – CAUTION! – TAKE ACTION	**TAKE QUICK RELIEF MEDICINE**

ASTHMA GETTING WORSE

You may have:
- Coughing
- Wheezing
- Chest Tightness
- First signs of a cold
- Coughing at night

Peak flow number from _____ **to** _____

Continue to use green zone daily medicines and add:

Medicine	**Method**	**How much**	**How often**
Albuterol/Xopenex	Inhaled	____ puffs OR ____ vial	Every ____ hours prn

_______ May repeat after 20 minutes x 1 (indicate with check)

Also take:

________ ________ ________ ________

If yellow zone symptoms continue for 24 hours or child needs extra rescue medicine more than 2 times per week, call your child's doctor.

RED ZONE – STOP! – GET HELP NOW!	**TAKE QUICK RELIEF MEDICINE**

THIS IS AN EMERGENCY!!!

You may have:
- Quick relief medicine that is not helping
- Wheezing that is worse
- Faster breathing
- Blue lips or nail beds
- Trouble walking or talking
- Chest and neck pulled in with each breath

Or Peak flow less than _____

Continue to use green zone medicines and do the following:

Use _____ puffs or 1 vial Albuterol/Xopenex inhaled every 20 minutes for a total of _____ doses.

CALL DOCTOR NOW!! If you cannot reach doctor, **CALL 911** or go directly to the **EMERGENCY ROOM .... DO NOT WAIT!!**

Physician Signature ______________________ **Date** ____________

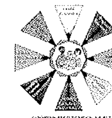
Parent/Guardian Signature ______________________ **Date** ____________

School Health Nurse Signature ______________________ **Date** ____________

SCHOOL NURSE ONLY: *Student self carries inhaler* ***Y / N*** *Inhaler in the Health Room* ***Y / N*** *Inhaler in classroom* ***Y / N***

AUTHORIZATION FOR SELF-MEDICATION BY STUDENTS AT

____



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Student's Name __________________________ **Birthdate**__________________________

Medication ______________________________ **for** ____________________________

Eligibility: In accordance with ____
Administering Medications to Students, only students who meet the following descriptions may possess and self-administer medications:
Students with special medical needs such as asthma and/or severe allergies or who are subject to anaphylactic reactions and may require emergency medications (i.e., asthma inhaler or epinephrine auto-injector (Epi-Pen).

Healthcare Provider: *The student named above has asthma or an allergy that could result in an anaphylactic reaction and may require emergency medications. This student is capable of, has been instructed on the procedures for and has demonstrated the skill to self-administer this medication. Please allow him/her to self-administer the medication during school hours as indicated on the Asthma Action Plan or Anaphylaxis Plan.*
This student will **not** require adult supervision while taking this medication. I have informed this student that he/she must tell an appropriate staff member whenever he/she has used the medication at school.

Physician Signature ______________________________ **Date** ______________________

Parent/Guardian: I give consent to the ____
to allow my child to self-administer this medication at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medication. If the medication that is prescribed for my child is for the treatment of asthma or anaphylactic reactions, I agree to provide a supplementary supply of the medication that will be kept by the school in a location to which my child has immediate access. I absolve the __________________________________ from any and all liability whatsoever that may result from my child possessing or taking this medication at school. I have informed my child that he/she must tell an appropriate staff member whenever he/she has used the medication at school.

Parent Signature ______________________________ **Date** ______________________

Student: I am capable of taking this medication as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to discipline under the Student Code of Conduct if I abuse the privilege of being allowed to self-medicate while at school or school sponsored activities. I understand that I will lose the privilege of self-administering my medication if I do not follow these rules. I further understand that if I have the need to use my asthma rescue medication more than one time, I will inform the appropriate office staff.

Student Signature ______________________________ **Date** ______________________

School Nurse: I have reviewed this request and acknowledge that this student has demonstrated the skill level to self-administer this medication. I have informed this student that he/she must tell an appropriate staff member whenever he/she has used the medication at school.

Nurse Signature ______________________________ **Date** ______________________