Anchorage School District

Seizure Care Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

Student Photo

SEIZURE TYPE

☐ **Absence (petit mal)** A period of unconsciousness with a blank stare or what looks like daydreaming. The person may lose muscle control and make repetitive movements.	Frequency: Duration:	**Interventions** • Stay calm and track time • Keep the child safe • Do not restrain the child • Do not put anything in the child's mouth • Stay with the child until fully conscious • Document the seizure occurrence
☐ **Myoclonic** Consciousness and memory are not impaired. Muscle jerks may occur in parts or all of the body.	Frequency: Duration:	
☐ **Tonic-clonic/convulsive (grand mal)** The child will lose consciousness from the start of the seizure. The muscles will stiffen (tonic phase), causing him/her to fall to the floor. The extremities then jerk and twitch rhythmically (clonic phase). Child may froth at the mouth. Breathing may be irregular. The person will regain consciousness slowly.	Frequency: Duration:	**Interventions** • Protect the child's head • Keep airway open • Watch breathing • Turn child on side If child has a tonic-clonic/convulsive seizure lasting longer than 5 minutes or repeated seizures without regaining consciousness: CALL 911 and ADMINISTER EMERGENCY MEDICATION AS PRESCRIBED.

TRIGGERS OR WARNING SIGNS

☐ Stress ☐ Lack of sleep ☐ Intense Emotions ☐ Boredom ☐ TV/Laptop/Phone/Tablet
☐ Fever ☐ Flashing lights ☐ Bright lights ☐ Other: _____

CHILD'S RESPONSE FOLLOWING SEIZURE

EMERGENCY MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY	INDICATION
☐ Diazepam (Diastat)				For seizures lasting longer than ___ minutes.
☐ Midazolam				For seizures lasting longer than ___ minutes.
☐ Other:				

ADDITIONAL CONSIDERATIONS

☐ Allowed to participate in usual school activities, including physical education.
☐ Has vagal nerve stimulator. Describe: _____
☐ Requires special consideration or safety precautions. Describe: _____

MEDICAL PROVIDER NAME/TITLE	*PHONE NUMBER*	*EMAIL*
MEDICAL PROVIDER SIGNATURE		*DATE*

THESE ORDERS EXPIRE AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL

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DAILY SEIZURE TREATMENT PROTOCOL		
PRESCRIBED DAILY MEDICATION	**DOSE**	**COMMON SIDE EFFECTS**

PARENT/GUARDIAN AGREEMENT AND AUTHORIZATION

I request that the medication(s) selected and seizure protocols listed on this plan be provided to my child. I will provide needed medications or supplies for care in school. Prescription medication must be in the original pharmacy container labeled with the following information: name, medication, dosage, route, administration time, ordering healthcare provider, pharmacy, date issued, and prescription number. I understand that, in the absence of the nurse, other trained Anchorage School District ("ASD") personnel may administer this medication.

Employees and agents of ASD strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify ASD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and ASD as part of the provision of my child's care. I agree for the nurse to share health information with ASD staff on a need-to-know basis for my child's safety and to foster academic success. I understand that ANY remaining medication(s) will be disposed of at the end of the school year, unless I pick up the remaining medication(s) by the last school day, as indicated on the ASD school year calendar.

THIS CARE PLAN EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL.

PARENT/GUARDIAN NAME	***RELATIONSHIP TO STUDENT***	***PHONE NUMBER***
PARENT/GUARDIAN SIGNATURE		***DATE***

NURSE PLAN REVIEW

I have reviewed the Seizure Care Plan for accuracy and ensure that all required fields and signatures are completed before administering medication to a student. I approve of the agreement arranged between the physician, parent, nurse, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME	
NURSE SIGNATURE	***DATE***