Anchorage School District

SEIZURE CARE PLAN

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

STUDENT PHOTO

SEIZURE TRIGGERS OR WARNING SIGNS

☐ Stress ☐ Intense emotions ☐ Boredom ☐ Lack of sleep ☐ Fever

☐ Television, videos, flashing lights ☐ Other: _____

SEIZURE TYPE	LENGTH	FREQUENCY	DESCRIPTION
☐ Absence seizures (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.
☐ Tonic-clonic or convulsive seizures (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 will then jerk and twitch rhythmically (clonic phase). Child may froth at the mouth. Breathing may be irregular. The person will regain consciousness slowly.
☐ Myoclonic seizures			Consciousness and memory are not impaired. Muscle jerks may occur in parts or all of the body.
☐ Other			

CHILD'S RESPONSE AFTER SEIZURE: _____

BASIC SEIZURE FIRST AID	SEIZURE EMERGENCY PROTOCOL
• 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 **For a tonic-clonic or convulsive seizure** • Protect the child's head • Keep airway open • Watch breathing • Turn child on side	If child has a tonic-clonic or convulsive seizure lasting longer than 5 minutes or repeated seizures without regaining consciousness: CALL 911 and ADMINISTER EMERGENCY MEDICATION AS PRESCRIBED.

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

☐ **YES** ☐ **NO** **Does this child have a vagal nerve stimulator?** *If yes, please describe use:*

☐ **YES** ☐ **NO** **Does this child require any special considerations or safety precautions?** *If yes, please describe use:*

☐ **YES** ☐ **NO** **Is this child allowed to participate in usual school activities, including physical education?**

MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY IN ALASKA AUTHORIZATION

(Provider: please have parent/guardian sign Authorization & Agreement on page 2 of 2)

PRINTED NAME/CREDENTIALS		SIGNATURE
DATE	PHONE	FAX

Anchorage School District

SEIZURE CARE PLAN

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

PARENT / GUARDIAN AGREEMENT & 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.**

Employees and agents of the Anchorage School District ("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.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

EMERGENCY CONTACTS		
NAME	**RELATIONSHIP TO CHILD**	**PHONE**

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 child. I approve of the agreement arranged between the physician, parent, nurse, and child for the management of the child's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the child in the school setting.

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE