Owensboro Catholic Schools

Student Plan of Care for Seizures

STUDENT INFORMATION

Name: _____ **Date of Birth:** _____

School Year: 20_____ – 20_____ **Grade:** _____ **Current Age:** _____

Pediatrician: _____ **Neurologist (if different):** _____

EMERGENCY CONTACT INFORMATION

Parent/Guardian #1 Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Parent/Guardian #2 Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

PARENT/GUARDIAN TO COMPLETE THE FOLLOWING:

1. Type(s) and description of this student's seizures:

2. How long do the seizures normally last?

3. How often do seizures occur?

4. Approx. date of student's last seizure and how long did it last?

5. What will trigger a seizure?

6. Does the student have an aura (warning sign of impending seizure)? If so, describe:

7. List any medications prescribed for this student:

8. List any activity restrictions for this student:

9. Is there any other information you would like for the OCS School Nurse/Health Coordinator to know about your student or his/her seizures? If so, describe:

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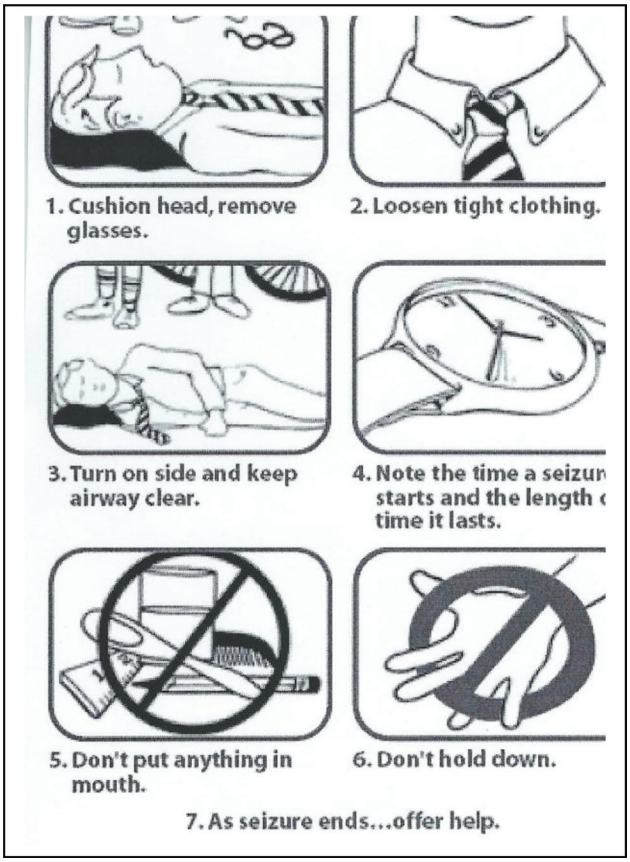
EMERGENCY TREATMENT FOR SEIZURES



Management During the Seizure:

Management of a seizure is limited to preventing injury:

1. If you see a seizure is starting, attempt to prevent injury by easing the student to floor. Keep hard, sharp or hot objects out of the way.
2. Stay calm.
3. **Turn student to the side** to allow saliva to drain and to prevent choking.
4. Protect student from injury but **do not restrain movement**. You may place a soft item or your hands under the head to protect the head from the flood.
5. **Do not force anything between teeth or place any object in mouth.**
6. **Do not give fluids or food during or immediately after seizure.**
7. **Loosen restrictive clothing.**
8. Note time of seizure onset and duration of seizure.
9. Observe:
   a. Injury
   b. Color of lips, face and skin
   c. Breathing may stop or be shallow during seizure
   d. Length of seizure (by clock) – Check the clock at the beginning of the seizure and at the end; note the length of the seizure.
10. Call Emergency Medical Services (EMS) (911) immediately if the seizure lasts longer than _____ minutes or if student is not breathing.
    a. If seizure lasts longer than five (5) minutes
    b. If there is any continued, progressive respiratory distress
    c. If another seizure starts right after the first
    d. Breathing becomes difficult or the person appears to be choking
    e. The seizure occurs in water
    f. Injury may have occurred
    g. The person asks for medical help
11. Administer emergency medication if ordered (OCS School Nurse will include approved manufacturer drug-specific administration instructions with this document).

    Check applicable Medication:

    a. ☐ Intrabuccal Klonopin (Clonazepam) When to administer: _____
    b. ☐ Diastat Rectal Gel: When to administer: _____
    c. ☐ Midazolam Intranasal: When to administer: _____
    d. ☐ Nayilzam Intranasal: When to administer: _____

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EMERGENCY TREATMENT FOR SEIZURES

Management After the Seizure has stopped:

1. When the seizure is finished, the student may be sleepy which is normal. Provide a comfortable, private place for rest where he/she can be observed.
2. Assess consciousness/movement
3. Monitor breathing
4. Check for injuries
5. Tell the student where he/she is, what time it is and what happened. Keep student quiet & comfortable
6. Notify parent and school nurse of any seizure activity or injury
7. Let student rest until full consciousness returns, then may offer light food/drink
8. Per student's Plan of Care and discussion with student's parent/guardian and School Nurse, student may return to class, be sent home from school with parent/guardian or parent/guardian designee, or transported to nearest Emergency Room per EMS.

It is the responsibility of the parent/guardian to provide any needed medications or supplies to the school and notify the school of any changes.

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Student's Seizure Plan of Care reviewed and approved by:

Parent/Guardian Name (Signature): _____ **Date:** _____

☐ *Please check this box if you understand that by typing your name, it is the same as your signature*

School Nurse Signature: _____ **Date:** _____

Principal Signature: _____ **Date:** _____

Healthcare Provider's Signature: _____ **Date:** _____

Healthcare Provider's Signature Note: If a separate Emergency Care Plan, also known as an "Action Plan," is obtained and signed by the Healthcare Provider, then the Healthcare Provider's signature on the Action Plan will supersede his/her signature on the OCS Student Plan of Care for Seizures.

Authorization to Release and Disclose Patient Information for School Year 20____–20____

I understand that the OCS School Nurse/Health Coordinator may have questions and require clarification from the student's Health Care provider to assist in the treatment and care concerning this student. As the parent/guardian of (student's name) _____, I hereby give my permission for exchange of confidential protected health information regarding this student between the OCS School Nurse/Health Coordinator and this student's Healthcare Provider and my signature is an informed consent to share necessary medical information with specified OCS school staff as a "need to know" for academic success and emergency plan as determined by the OCS School Nurse/Health Coordinator.

Parent/Guardian Name (Signature): _____ **Date:** _____

☐ *Please check this box if you understand that by typing your name, it is the same as your signature*