

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School Year: 20\_\_ - \_\_\_\_

Grade: \_\_\_\_\_ Current Age: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Neurologist: (if different): \_\_\_\_\_

Parent/Guardian Emergency Contact #1	Phone#	Parent/Guardian Emergency Contact #2	Phone#
Name:	H:	Name:	H:
Relationship:	C:	Relationship:	C:
	W:		W:

**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:

**Emergency Treatment For Seizures**

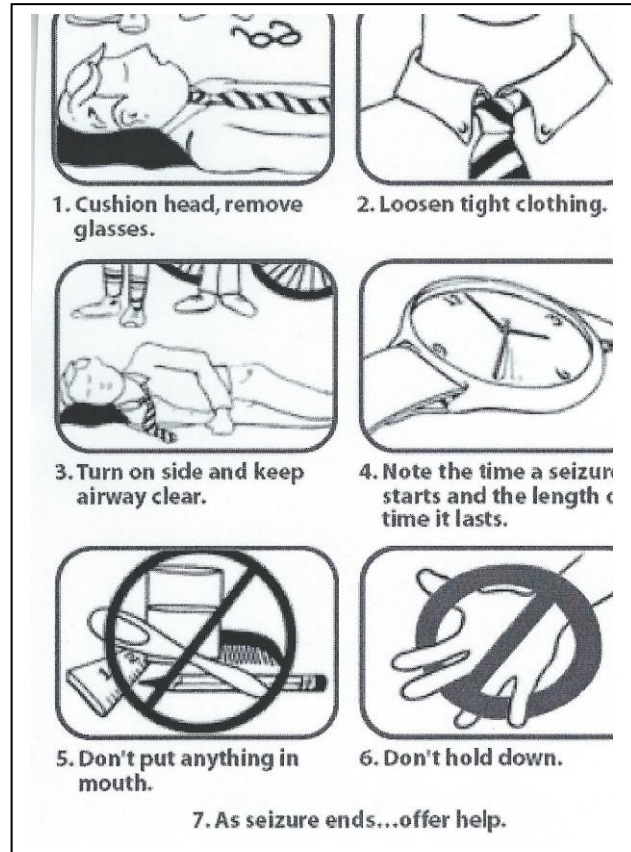
**Management During the Seizure:**

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 floor.
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). See below for administration summary

Circle applicable Medication:

- a. Intrabuccal Klonopin (Clonazepam): When to administer: \_\_\_\_\_
- b. Diastat Rectal Gel: When to administer: \_\_\_\_\_
- c. Valtoco Intranasal: When to administer: \_\_\_\_\_
- d. Nayilzam Intranasal: When to administer: \_\_\_\_\_



**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.

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

\_\_\_\_\_  
Parent/Guardian Signature      Date

\_\_\_\_\_  
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\_\_ - \_\_\_\_**

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 (PRINT)

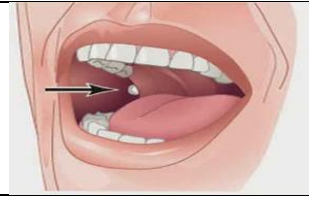
\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

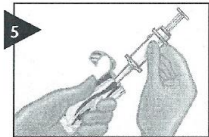
**Administration of Emergency Medication Summary:**

**Intrabuccal Klonopin (Clonazepam):**

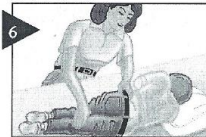
place tablet inside of cheek



**Rectal Diastat:**



Lubricate rectal tip with lubricating jelly.



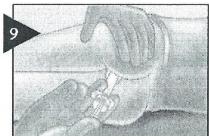
Turn person on side facing you.



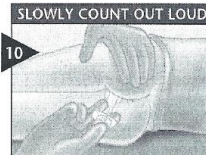
Bend upper leg forward to expose rectum.



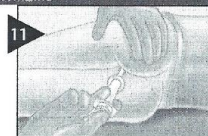
Separate buttocks to expose rectum.



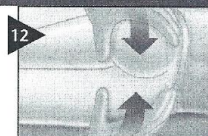
Gently insert syringe tip into rectum. *Note: Firm should be snug against rectal opening.*



Slowly count to 3 while gently pushing plunger in until it stops.



Slowly count to 3 before removing syringe from rectum.



Slowly count to 3 while holding buttocks together to prevent leakage.

**Intranasal Valtoco:**

Note the dosage—  
5, 10, 15, 20 mg.  
If 15mg or 20 mg, you will use **both** sets in the box



Peel back the tab with the arrow on the corner of the pack.



Remove the first VALTOCO from the pack.

INSERT the tip of the nozzle into 1 nostril until your fingers, on either side of the nozzle, are against the bottom of the person's nose.



PRESS the bottom of the plunger firmly with your thumb to give VALTOCO



**Intranasal Nayzilam:**

**HOLD**

Hold the nasal spray device with your thumb on the plunger and your middle and index fingers on each side of the nozzle.



**DO NOT PRESS THE PLUNGER YET.**

**PLACE**

Place the tip of the nozzle into one nostril until your fingers are against the bottom of the patient's nose.



**PRESS**

Press the plunger firmly.

