BONNIE CONE CLASSICAL ACADEMY

SEIZURE ACTION PLAN FOR SCHOOL

Student Name _____D.O.B._____ ID # _____

School _____ Teacher_____

Physician Phone: _____

EMERGENCY CONTACTS

	Relationship	Home #	Work #	Cell #
1.				
2.				
3.				

Type of seizure: _____

What does the seizure look like and how long does it usually last? _____

_____

Possible triggers that should be avoided: _____

_____

Does student need any special activity adaptations/protective equipment (e.g., helmet) at school? _____

_____ No _____ Yes (explain) _____

Is student allowed to participate in physical education and other activities?

_____ No _____ Yes (explain) _____

_____

ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES? No Yes

(List below the medications needed)

_____Vagus Nerve Stimulator implant (see VNS management order attached)

MEDICATIONS AMOUNT TAKEN HOW OFTEN AND FOR WHAT SIGNS

1. _____

2. _____

3. _____

Possible side effects that must be reported to parent or physician:

_____

_____

IF GENERALIZED SEIZURE OCCURS:

1. If falling, assist student to floor, turn to side.

2. Loosen clothing at neck and waist; protect head from injury.

3. Clear away furniture and other objects from area.

4. Have another classroom adult direct students away from area.

5. **TIME THE SEIZURE.**

6. Allow seizure to run its course; **DO NOT** restrain or insert anything into student's mouth. Do not try to stop purposeless behavior.

7. During a general or grand mal seizure expect to see pale or bluish discoloration of the skin or lips. Expect to hear noisy breathing.

IF SMALLER SEIZURE OCCURS (e.g., lip smacking, behavior outburst, staring, twitching of mouth or hands)

1. Assist student to comfortable, sitting position.

2. **TIME THE SEIZURE.**

3. Stay with student, speak gently, and help student get back on task following seizure.

IF STUDENT EXHIBITS:

1. Absence of breathing or pulse.

2. Seizure of 10 minutes or greater duration.

3. Two or more consecutive (without a period of consciousness between) seizures which total 10 minutes or greater.

4. Continued unusually pale or bluish skin or lips or noisy breathing after the seizure has stopped.

INTERVENTION:

1. **Call 911**.

2. **START CPR for absent breathing or pulse.**

WHEN SEIZURE COMPLETED:

1. Reorient and assure student.

    a. Assist change into clean clothing if necessary.
    b. Allow student to sleep, as desired, after seizure.
    c. Allow student to eat, as desired, once fully alert and oriented.

2. A student recovering from a generalized seizure may manifest abnormal behavior such as incoherent speech, extreme restlessness, and confusion. This may last from five minutes to hours.

3. Inform parent immediately of seizure via telephone conversation if:

a. Seizure is different from usual type or frequency or has not occurred at school in past month.
b. Seizure meets criteria for 911 emergency call.
c. Student has not returned to "normal self" after 30-60 minutes.

4. Record seizure on Seizure Activity Log.

If you want additional care given, describe action here:

If symptoms are _____

_____

Give_____ (medication/dose/route)

Possible side effects _____

_____

Physician Signature_____ Date_____

Print Name_____ Phone_____

‰I want this plan implemented for my child, _____, in school. I hereby give my permission for exchange of confidential information contained in the record of my child between the nurse and physician and my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

Parent/Guardian Signature: _____Date: _____

‰Approved by School Nurse

School Nurse Signature: _____Date: _____

BONNIE CONE CLASSICAL ACADEMY

MEDICATION PRESCRIBER/PARENT AUTHORIZATION FOR VAGUS NERVE STIMULATOR (VNS)

School Year: _____ _____

STUDENT INFORMATION

Student's Name _____ School: _____

Date of Birth: ____/____/____ Grade _____ Teacher _____

Known drug allergies/reactions If drug allergies, list: Weight: lbs.

PRESCRIBER AUTHORIZATION
(To be completed by licensed healthcare provider)

START DATE: _____ **STOP DATE:** _____

Procedure: Swiping magnet over student's VNS

Reason for procedure: To shorten duration of, or stop, seizure activity.

How & frequency r/t swipe delivery: Swipe magnet over VNS for full 1-2 second time period, at onset of seizure activity.

Repeat swipe X _____ if seizure activity does not cease after _____ minute(s).

If magnet is held in place over the VNS for longer than 60 seconds at one time, the generator will be turned off until the magnet is removed. Once magnet is removed, the device will resume its normal cycle.

Do you recommend the magnet be kept "on person" by the student? □ Yes □ No
If "no", storage location of magnet will be identified in student's Individualized Healthcare Plan.

Potential Contradictions/Adverse Reactions: _____

_____
Printed Name of Licensed Healthcare Provider

_____ _____ _____ _____
Signature of Licensed Healthcare Provider **Date** **Phone** **Fax**

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to assist my child in the above procedure, and to delegate to trained, unlicensed school personnel, the task of assisting my child with the above prescribed procedure, in accordance with administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure. Procedure equipment or supplies must be registered with the school nurse or his/her designee.

_____ _____ _____
Signature of Parent **Date** **Phone**