Emergency Care Plan effective __________ to __________  
Review date ______

Student name_________________________  School year ________________

Parent phone _________________________  Parent cell ____________________

Alternate contact (name & relationship) __________________________  Phone ______

Primary physician (name) ______________________  Phone ______

<table>
<thead>
<tr>
<th>STUDENT SPECIFIC DATA FOR CLASSROOM</th>
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<tbody>
<tr>
<td>If you see this:</td>
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<thead>
<tr>
<th>STUDENT SPECIFIC DATA FOR COMMUNITY</th>
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</table>

Additional comments:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

School Nurse
Phone
Rev. 1/28/05
Dear Parent/Guardian,

Your child's health record indicates a history of seizure disorder. In order to provide safe, appropriate health care at school, please complete the attached two sided "Questionnaire for Parent of a Student with Seizures" form and return to me as soon as possible. Written instructions from your child's physician must be provided to ensure proper care before, during, and after a seizure. Attached is a "Seizure Action Plan" to be completed by you AND your child's physician.

As your child is seen by his/her physicians, please ask them to provide written instructions for any changes in health care interventions or medications. Please give this written information to me as soon as possible.

If you have any questions, please call me at _________________. Forms may be brought in person, faxed to me at ___________________________ or mailed to ___________________________.

Thank you.

Sincerely,

School Nurse

Rev. 5/4/09
INSECT STING ALLERGY

Student: ____________ Grade: ______ School Contact: ____________ DOB: ____________
Asthmatic: □ Yes □ No (increased risk for severe reaction) Severity of reaction(s): ____________
Mother: ___________________ MHome #: ______ MWork #: ______ MCell #: ______
Father: ___________________ FHome #: ______ FWork #: ______ FCell #: ______
Emergency Contact: ____________ Relationship: ________ Phone: ________

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

• MOUTH  Itching & swelling of lips, tongue or mouth
• THROAT  Itching, tightness in throat, hoarseness, cough
• SKIN  Hives, itchy rash, swelling of face and extremities
• STOMACH  Nausea, abdominal cramps, vomiting, diarrhea
• LUNG  Shortness of breath, repetitive cough, wheezing
• HEART  “Thready pulse”, “passing out”

The severity of symptoms can change quickly – it is important that treatment is given immediately.

STAFF MEMBERS INSTRUCTED:
□ Classroom Teacher(s) □ Special Area Teacher(s)
□ Administration □ Support Staff □ Transportation Staff

TREATMENT: Notify the nurse. If trained by nurse, remove stinger if visible, rinse contact area with water, and apply ice.
Antihistamine ordered: □ Yes □ No Give (type/dose ___________________) should be given □ when stung/or waiting for symptoms □ if the following symptoms are seen:

If off of school grounds, call the parent/guardian (see above) and school nurse at ________
Epinephrine ordered: □ Yes □ No (dosage) ______ should be given □ when stung/or waiting for symptoms □ if the following symptoms are seen:

IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING AT THE SITE OF THE STING ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.
Preferred Hospital: ____________ Stay with student until EMS arrives and begin CPR if necessary. Keep student calm and lying on back with legs raised. Note time epinephrine given. Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine must be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Transportation Plan: □ Medication available on bus □ Medication NOT available on bus □ Does not ride bus

Special instructions: ______________________

Written by: ________________________ Date: ____________ Phone: ____________

Physician/Healthcare Provider: signature ______________________ Phone: ________

Parent/Guardian Signature to share this plan with Provider and School Staff: ______________________

This plan is in effect for the current school year and summer school as needed. Revised 6/21/11
# SSD Seizure Health Care Plan

**NAME:**

<table>
<thead>
<tr>
<th>Brief history of seizures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seizure type:</td>
</tr>
</tbody>
</table>

**Diastat:** yes/no  
Order: ________________________________

**Vagus nerve stimulator:** yes/no  
Order: ________________________________

**PRN medicine:** yes/no  
Order: ________________________________

**Ketogenic diet:** yes/no  
Order: ________________________________

<table>
<thead>
<tr>
<th>School:</th>
<th>Date of Birth:</th>
<th>Grade:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bus #</td>
<td>Doctor name/number:</td>
<td>Daily meds. at school</td>
</tr>
</tbody>
</table>

## Individual Considerations

**Nursing Diagnosis:** Potential for injury related to uncontrolled movements of seizure or extended seizure.

**Goal:** Prevent injury and follow seizure action plan.

**Interventions:**
1. RN will obtain *Seizure questionnaire form* from parent/guardian as needed. (received_)  
2. RN will obtain *Seizure Action Plan* signed by parent and physician yearly. (received_)  
3. RN will in-service staff on student's seizure action plan at the beginning of the school year. (completed ___)

**Bus – Transportation** should be alerted to student's seizure condition.

**Specific training required:** yes/no  
Training completed: ________________________________

- This student carries a magnet for VNS on the bus: _Yes_ _No_  
- Magnet can be found in: _Backpack_ _Waistpack_ _On Person_  
- Other (specify): ________________________________

- Student will sit at front of the bus: _Yes_ _No_  
- Other (specify): ________________________________

**CLASSROOM – Staff must follow student’s individual seizure action plan.**

- At least one staff member trained in seizure monitoring must be available at all times.  
- Staff must record all seizure activity on the daily seizure log and share information with parents.  
- Classroom staff will notify RN if: ________________________________

- Classroom staff will provide a safe classroom environment:
  - Student wears a helmet while at school  
  - Reduce or remove clutter in classroom that may cause injury during a seizure  
  - Provide safe seating in the classroom (keep student away from table/desk edges, provide chair with arms)  
  - Keep blanket or pillow available to cushion student’s head during a seizure.  
  - Classroom staff will be trained in Diastat use  
  - Classroom staff will be trained in VNS use  
  - Ketogenic diet will be provided by parents. No additional foods should be given without parent permission.

- Student should have someone accompany him/her in the hallways and restroom: _Yes_ _No_  
- Other (specify): ________________________________
**Field Trip Procedures** - Emergency plan should accompany student during any off campus activities.

- Student should remain with the teacher or parent/guardian during the entire field trip: **Yes** **No**
- Staff trained in VNS/Diastat use must accompany the student on a field trip: **Yes** **No**
- Other (specify) ____________________________________________

**CAFETERIA**

- **NO Restrictions**
- **Student follows ketogenic diet**
- **Other:**

See attached Emergency (Seizure) Action Plan

Nurse name/contact number: _______________________________________

Nurse signature/date: ____________________________________________
Dear ________________,

We have been made aware that your child may require specialized nursing intervention or treatment (specifically ___________, while at school.

The District's policy regarding specialized nursing intervention or treatment includes the following:

- Only procedures which "must" be done during the hours your child is in school, and cannot be done at home before or after school will be provided.
- A physician's order is required, specifying the treatment protocol, indications, and precautions (Specialized nursing intervention/treatment form).
- Parental consent signature is also required on the "specialized nursing intervention/treatment form."
- The "specialized nursing intervention/treatment form" must be submitted annually prior to the beginning of each school year, and at the time of any changes in treatment.
- The parent/guardian must provide the school with any necessary equipment, supplies, and medication for the treatment if required (current prescription bottle with directions for use).

The procedures will be administered by the school registered nurse or a staff member designated and trained by the nurse.

Orders needed:

__________________________________________

__________________________________________

Please return all forms as soon as possible. The forms may be returned in person, by mail to: ____________________________________________ or by fax to: __________________________.

If you have any questions, please contact me at ________________. Thank you for your cooperation.

Sincerely,

______________________________
School Nurse

Rev. 5/20/09
PARENT CONSENT/REQUEST FOR SPECIALIZED NURSING INTERVENTION OR TREATMENT

I give my permission for the school nurse or a staff member trained by the school nurse to perform the following specialized nursing intervention or treatment prescribed by __________ (Physician or Licensed Care Provider) and to contact the Physician regarding any treatment orders, the implementation of the orders, and the outcomes from these treatments. I request that the school continue the intervention or treatment for the duration of the school year or until notified by me or the Physician to change or discontinue. Notice of change must be received in writing. Orders must be renewed annually.

_________________________  __________________________
Parent/guardian signature  Date

PHYSICIAN'S ORDER FOR SPECIALIZED NURSING INTERVENTION OR TREATMENT

Your assistance is necessary for appropriate health management in the school setting. Please provide detailed orders for any PPS needed at school for the 20__-20__ school year.

Name of student ___________________ Birth date ______________

Condition to be treated ___________________________

Specialized nursing intervention or treatment _________________________

Prescribed treatment protocol:

________________________________________________________________________

Time schedule and/or indications: __________________________________________

Precautions, possible side effects, and recommended interventions:

________________________________________________________________________

I am aware that this treatment may be delegated by the school registered nurse to an unlicensed staff member who is trained and supervised by the nurse.

Physician name (please print) ___________________ Address ___________________ Phone ______________

Physician Signature __________________________________ Date __________________

If completed by a nurse practitioner, please indicate the physician in collaborative practice.

Please return by mail or fax to the address or fax # below:

School Address ___________________ Fax ____________________________

Rev. 5/20/09
SPECIAL SCHOOL DISTRICT
HEALTH SERVICES

PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF
MEDICATIONS AT SCHOOL

I request and give my permission for Special District Registered Nurses, or their
designee, to administer the following medication(s) (listed below) to my
child ___________________ and to consult with my child’s
physician(s) _______________ at (phone) ___________ regarding any concern
or questions in reference to the administration of medication during the
_____/______ school year.

Please list each medication you are requesting your child be given at school

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dose</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<tr>
<td>5.</td>
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</tbody>
</table>

All medications to be administered at school must be given to the school nurse in a
current pharmacy container labeled with the following information:

- Child’s name
- Authorized provider’s name
- Pharmacist’s name and phone
- Date prescription filled
- Specific instructions for administering
- Name of medication
- Prescription number.

We will not administer any medication unless labeled as above. This may require that
your child’s authorized provider write two prescriptions (one for home use and one for
school use) so the pharmacist can separate the medication into two labeled containers.
Some pharmacies will provide you with a “school bottle”.
Exception: Over the counter medication must be brought in an unopened bottle and be
accompanied by a written prescription from the physician.

It is the parent’s/guardian’s responsibility to notify the school nurse when
medication is changed and/or discontinued.

Parent/Guardian signature  ____________________________ Date  ____________

Rev. 4/14/09
SCHOOL ASTHMA ACTION PLAN

Immediate action is required when the student exhibits ANY of the following signs of respiratory distress. Always treat symptoms even if a peak flow meter or electronic flow meter is not available. If a peak flow meter or electronic flow meter is available, check for airflow obstruction (FEV1 preferred or peak flow if FEV1 is not available) prior to giving quick relief medicine and every 20 minutes to assess need for additional doses.

☐ Severe cough     ☐ Shortness of Breath     ☐ Sucking in of the chest wall     ☐ Difficulty breathing when walking
☐ Chest tightness  ☐ Turning blue     ☐ Shallow, rapid breathing     ☐ Difficulty breathing while talking
☐ Wheezing        ☐ Rapid, labored breathing     ☐ Blueness of fingernails & lips     ☐ Decreased or loss of consciousness

Steps to Take During an Asthma Episode:
1. Give Emergency Asthma Medications As Listed Below:

<table>
<thead>
<tr>
<th>Quick Relief Medications</th>
<th>Dose/Frequency</th>
<th>When to Administer</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

2. Contact Parents if ___________________________________________________________

3. Call 911 to activate EMS if the student has ANY of the following:
   ➢ Lips or fingernails are blue or gray
   ➢ Student is too short of breath to walk, talk, or eat normally
   ➢ Chest and neck pulling in with breathing
   ➢ Child is hunching over
   ➢ Child is struggling to breathe
   OR
   ➢ The quick-relief medicine is not helping (breathing should improve within 15 minutes after quick-relief medicine is given)

Note: For a severe, life-threatening asthma episode, activate EMS. The Guidelines for the Diagnosis and Treatment of Asthma - Expert Panel Report 3 (2007) recommend a short-acting beta-agonist (i.e. Albuterol), 2-6 puffs with a spacer/spacer with mask. If the child is not receiving emergency care in 20 minutes, guidelines recommend repeating this dose.

Parent/Legal Guardian Signature _________________________ Date __________
Reviewed by School Nurse _________________________ Date __________

Telephone Contact
Date ____________ Person ______________________________

Additional Examples of Asthma Action Plans
1. http://www.rampasthma.org/info-resources/asthma-action-plans/
Assessment for: ________________________________ Completed by: ___________________________ Date: ___________

(Student) (Nurse or Parent)

This tool assists the school nurse in assessing if students are achieving good control of their asthma. Its use is particularly indicated for students receiving intensive case management services at school.

**With good asthma management, students should:**
- Be free from asthma symptoms or have only minor symptoms:
  - no coughing or wheezing
  - no difficulty breathing or chest-tightness
  - no waking at night due to asthma symptoms
- Be able to go to school every day, unhampered by asthma.
- Be able to participate fully in regular school and daycare activities, including play, sports, and exercise.
- Have no bothersome side effects from medications.
- Have no emergency room or hospital visits.
- Have no missed class time for asthma-related interventions or missed class time is minimized.

**Signs that a student's asthma is not well controlled:**
Indicate by checking the appropriate box whether any of the signs or symptoms listed below have been observed or reported by parents or children within the past 2-4 weeks (6 months for history). If any boxes are marked, this suggests difficulty with following the treatment plan or need for a change in treatment or intervention (e.g., different or additional medications, better identification or avoidance of triggers).

- Asthma symptoms more than two days a week or multiple times in one day that require quick-relief medicine (short-acting beta2-agonists, e.g., albuterol).
- Symptoms get worse even with quick-relief meds.
- Waking up at night because of coughing or wheezing.
- Frequent or irregular heartbeat, headache, upset stomach, irritability, feeling shaky or dizzy.
- Missing school or classroom time because of asthma symptoms.
- Having to stop and rest at PE, recess, or during activities at home because of symptoms.
- Exacerbations requiring oral systemic corticosteroids more than once a year.
- Symptoms require unscheduled visit to doctor, emergency room, or hospitalization.
- 911 call required.

If you checked any of the above, use the following questions to more specifically ascertain areas where intervention may be needed.

<table>
<thead>
<tr>
<th>Probes</th>
<th>Responsible Person/Site</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medications</strong></td>
<td></td>
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<tr>
<td>Are appropriate forms completed and on file for permitting medication administration at school?</td>
<td>By school staff</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Self-carry</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Has a daily long-term-control medication(s)* been prescribed?</td>
<td>Home</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Is long-term-control medication available to use as ordered?</td>
<td>School</td>
<td>☐</td>
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<tr>
<td>Is the student taking the long-term-control medication(s) as ordered?</td>
<td>Home</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>School</td>
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<tr>
<td>Has a quick-relief (short-acting B2-agonist) medication been prescribed?</td>
<td>Home</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>Personal inhaler(s) at school health office</td>
<td>☐</td>
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<tr>
<td>Self-carry</td>
<td>☐</td>
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<tr>
<td>Is quick-relief medication easily accessible?</td>
<td>Home</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>School</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Is the student using quick-relief medication(s) as ordered…</td>
<td>Home</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>○ Before exercise?</td>
<td>School</td>
<td>☐</td>
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<tr>
<td>○ Immediately when symptoms occur?</td>
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</tbody>
</table>
### Medical Administration

<table>
<thead>
<tr>
<th>Question</th>
<th>Home</th>
<th>School</th>
<th>No</th>
<th>N/A</th>
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<tbody>
<tr>
<td><strong>Does the student use correct technique when taking medication?</strong></td>
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<tr>
<td><strong>Does the person administering the medication use correct technique?</strong></td>
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</table>

### Monitoring

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<tr>
<th>Question</th>
<th>Home</th>
<th>School</th>
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<th>N/A</th>
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<tbody>
<tr>
<td><strong>Can the student identify his/her early warning signs and symptoms that</strong></td>
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<td><strong>indicate the onset of an asthma episode and need for quick-relief</strong></td>
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<td><strong>medication?</strong></td>
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<tr>
<td><strong>Can the student identify his/her asthma signs and symptoms that</strong></td>
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<tr>
<td><strong>indicate the need for help or medical attention?</strong></td>
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<tr>
<td><strong>Can the student correctly use a peak flow meter or asthma diary for</strong></td>
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<td><strong>tracking symptoms?</strong></td>
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<tr>
<td><strong>Are the student's asthma signs and symptoms monitored using a Peak Flow,</strong></td>
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<tr>
<td><strong>verbal report, or diary?</strong></td>
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<tr>
<td><strong>Daily?</strong></td>
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<tr>
<td><strong>For response to quick-relief medication?</strong></td>
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<tr>
<td><strong>During physical activity?</strong></td>
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</tbody>
</table>

### Trigger Awareness

<table>
<thead>
<tr>
<th>Question</th>
<th>Home</th>
<th>School</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Have triggers been identified?</strong></td>
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<tr>
<td><strong>Can student name his/her triggers?</strong></td>
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</tr>
<tr>
<td><strong>Can parents/caregivers list their child's asthma triggers?</strong></td>
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<tr>
<td><strong>Are teachers, including physical educators, aware of this student's asthma triggers?</strong></td>
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</tbody>
</table>

### Trigger Avoidance

<table>
<thead>
<tr>
<th>Question</th>
<th>Home</th>
<th>School</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are triggers removed or adequately managed?</strong></td>
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</tbody>
</table>

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School nurses provide appropriate asthma education and health behavior intervention to students, parents, and school personnel when signs and symptoms of uncontrolled asthma and other areas of concern are identified. If there is an indication for a change in asthma medications or treatment regimen, refer the student and family to their primary care provider or asthma care specialist or help families to find such services as soon as possible.

*Long-term-control medications (controllers) include inhaled corticosteroids (ICS), leukotriene receptor antagonists (LTRA), or combination medicine (long-acting B2-agonists and ICS), cromolyn, or theophylline.*
SPECIAL SCHOOL DISTRICT SEIZURE ACTION PLAN
(Adapted from the Epilepsy Foundation, 3/24/09) Form #SZ 2

Effective Date _______

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A
SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name: ___________________ Date of Birth: ________
Parent/Guardian: ___________________ Phone: ________ Cell: ________
Treating Physician: ________________ Phone: ______________
Significant medical history: ________________________________

SEIZURE INFORMATION:

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
</table>

Seizure triggers or warning signs:

Student's reaction to seizure:

BASIC FIRST AID: CARE & COMFORT: (Please describe basic first aid procedures)

Does student need to leave the classroom after a seizure? YES NO
If YES, describe process for returning student to classroom

EMERGENCY RESPONSE:
A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol: (Check all that apply and clarify below)
☐ Contact school nurse at ________
☐ Call 911 for transport to ________
☐ Notify parent or emergency contact
☐ Notify doctor
☐ Administer emergency medications as indicated below
☐ Other ________________________

Basic Seizure First Aid:
✓ Stay calm & track time
✓ Keep child safe
✓ Do not restrain
✓ Do not put anything in mouth
✓ Stay with child until fully conscious
✓ Record seizure in log

For tonic-clonic (grand mal) seizure:
✓ Protect head
✓ Keep airway open/watch breathing
✓ Turn child on side

A Seizure is generally considered an Emergency when:
✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
✓ Student has repeated seizures without regaining consciousness
✓ Student has a first time seizure
✓ Student is injured or has diabetes
✓ Student has breathing difficulties
✓ Student has a seizure in water

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

<table>
<thead>
<tr>
<th>Daily Medication</th>
<th>Dosage &amp; Time of Day Given</th>
<th>Common Side Effects &amp; Special Instructions</th>
</tr>
</thead>
</table>

Emergency/Rescue Medication

Does student have a Vagus Nerve Stimulator (VNS)? YES NO
If YES, Describe magnet use

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: (regarding school activities, sports, trips, etc.)

Physician Signature: ___________________ Date: ________
Parent Signature: ___________________ Date: ________
SSD QUESTIONNAIRE FOR PARENT OF A STUDENT WITH SEIZURES

(Adapted from the Epilepsy Foundation 5/20/09) Form SZ #3

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

CONTACT INFORMATION:

Student's Name: __________________________ School Year: __________ Date of Birth: ________________

School: ___________________________ Grade: _______ Classroom: ___________________________

Parent/Guardian Name: ___________________________ Tel. (H): _______ (W): _______ (C): _______

Other Emergency Contact: ___________________________ Tel. (H): _______ (W): _______ (C): _______

Child’s Neurologist: ___________________________ Tel. ___________________________ Location: ___________________________

Child’s Primary Care Dr.: ___________________________ Tel. ___________________________ Location: ___________________________

Significant medical history or conditions:

SEIZURE INFORMATION:

1. When was your child diagnosed with seizures or epilepsy? __________________________

2. Seizure type(s):

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
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</table>

3. What might trigger a seizure in your child? __________________________

4. Are there any warnings and/or behavior changes before the seizure occurs? YES NO

If YES, please explain: __________________________

5. When was your child's last seizure? __________________________

6. Has there been any recent change in your child's seizure patterns? YES NO

If YES, please explain: __________________________

7. How does your child react after a seizure is over? __________________________

8. How do other illnesses affect your child's seizure control? __________________________

9. What basic first aid procedures should be taken when your child has a seizure in school?

   - Stay calm & track time
   - Keep child safe
   - Do not restrain
   - Do not put anything in mouth
   - Stay with child until fully conscious
   - Record seizure in log

For tonic-clonic (grand mal) seizure:

   - Protect head
   - Keep airway open/watch breathing
   - Turn child on side

Basic Seizure First Aid:

10. Will your child need to leave the classroom after a seizure? YES NO

    If YES, What process would you recommend for returning your child to classroom:

    ____________________________________________________________________

SEIZURE EMERGENCIES

Page 1 of 2
11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

12. Has child ever been hospitalized for continuous seizures? YES NO
   If YES, please explain: ________________________________________________________________
   ________________________________________________________________

SEIZURE MEDICATION AND TREATMENT INFORMATION

13. What medication(s) does your child take?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Date Started</th>
<th>Dosage</th>
<th>Frequency and time of day taken</th>
<th>Possible side effects</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

14. What emergency/rescue medications needed medications are prescribed for your child?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Administration Instructions (timing* &amp; method**)</th>
<th>What to do after administration:</th>
</tr>
</thead>
<tbody>
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</table>

* After 2nd or 3rd seizure, for cluster of seizures, etc.
** Oral, under tongue, rectally, etc.

A Seizure is generally considered an Emergency when:
✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
✓ Student has repeated seizures without regaining consciousness
✓ Student has a first time seizure
✓ Student is injured or diabetic
✓ Student has breathing difficulties
✓ Student has a seizure in water

15. What medication(s) will your child need to take during school hours?

__________________________________________________________________________________________

16. Should any of these medications be administered in a special way? YES NO
   If YES, please explain:
__________________________________________________________________________________________

17. Should any particular reaction be watched for? YES NO
   If YES, please explain:
__________________________________________________________________________________________

18. What Does your child have a Vagus Nerve Stimulator? YES NO
   If YES, please describe instructions for appropriate magnet use:
__________________________________________________________________________________________

SPECIAL CONSIDERATIONS & PRECAUTIONS

22. Check all that apply and describe any considerations or precautions that should be taken
   □ General health
   □ Physical functioning
   □ Learning:
   □ Behavior:
   □ Mood/coping:
   □ Physical education (gym)/sports:
   □ Recess:
   □ Field trips:
   □ Bus transportation:
   □ Other:

GENERAL COMMUNICATION ISSUES

23. What is the best way for us to communicate with you about your child's seizure(s)?

__________________________________________________________________________________________

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent/Guardian Signature: __________________________ Date: ___________ Dates Updated: ___________
Seizure Observation Record

SSD SEIZURE OBSERVATION RECORD
(adapted from Epilepsy Foundation 3/24/09) Form#SZ1

<table>
<thead>
<tr>
<th>Student Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date &amp; Time</td>
</tr>
<tr>
<td>Seizure Length</td>
</tr>
<tr>
<td>Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)</td>
</tr>
<tr>
<td>Conscious (yes/no/altered)</td>
</tr>
<tr>
<td>Injuries (briefly describe)</td>
</tr>
</tbody>
</table>

| Rigid/clenching |
| Limp |
| Fell down |
| Rocking |
| Wandering around |
| Whole body jerking |

| (R) arm jerking |
| (L) arm jerking |
| (R) leg jerking |
| (L) leg jerking |
| Random Movement |

| Bluish |
| Pale |
| Flushed |

| Pupils dilated |
| Turned (R or L) |
| Rolled up |
| Staring or blinking (clarify) |
| Closed |

| Salivating |
| Chewing |
| Lip smacking |

| Verbal Sounds (gagging, talking, throat clearing, etc.) |
| Breathing (normal, labored, stopped, noisy, etc.) |

| Confused |
| Sleepy/tired |
| Headache |
| Speech slurring |
| Other |

| Length to Orientation |
| Parents Notified? (time of call) |
| EMS Called? (call time & arrival time) |
| Observer's Name |

Please put additional notes on back as necessary.
SPECIAL SCHOOL DISTRICT
HEALTH SERVICES

PROTOCOL FOR ADMINISTRATION OF RECTAL VALIUM (DIASTAT)

Diastat is an emergency intervention drug used in an effort to control or stop status epilepticus or other seizures. The student’s physician must provide a written order for administration of this drug, including specific orders regarding when to administer.

1. When a seizure begins, the time will be reported on the seizure record.

2. The student’s color and respiratory status will also be noted on the record.

3. Administer the Diastat as ordered by the physician.

4. Call 911 unless otherwise directed by the physician. (If the nurse feels the child is in danger, 911 should be called for emergency care).

5. If the physician has stated that 911 is not necessary, and the nurse judges the child to be in a stable condition, parents or guardians will be called to take the student home.

6. The nurse will monitor the student’s respiratory status until EMS or the parent/guardian arrives to take the child home.

7. The nurse will complete the Record of Diastat Administration and place in the student’s health file.
Health Care Plan

Name:          DOB:          
Parent:        Phone:        
Doctor:        Phone:        
School          School Nurses:  

Student specific info:

A Seizure Disorder, also known as Epilepsy, is a disorder of the central nervous system characterized by a tendency for recurrent seizures. The term "seizure" refers to sudden, uncontrolled episode of abnormal behavior related to abnormal electrical discharges in the brain.

If you see this:

Do this:
1. Note the time the seizure starts.
2. Turn his head to the side to allow the saliva to drain.
3. Observe color of lips, face and skin and observe for any changes in her breathing.
4. Call school nurse to his location by 1 minute of seizure activity to assess and prepare emergency meds and oxygen.
5. If seizure spontaneously ends, remind ----- of where he is and that he is OK. Note the time seizure ended. ---------- may be very sleepy and may need to rest for some time afterwards.
6. School nurse should assess ------- before he sleeps if possible and will notify parent of seizure activity.

If you see this:
Seizure has continued for 3 minutes or student is having clusters of seizures. (One right after another.)
Student has a blue or pale color about lips or face, or he appears to not be breathing well.

Do this:
1. If the nurse has not already arrived, have her paged immediately to student’s location.
   Nurse should bring oxygen and Diastat with her or send someone to retrieve it from nurses’ office now.
   Oxygen may be started if needed, per nurse as directed by standing orders.
2. If ------ is out in the community and no nurse is available, call 911 and notify mom.
3. Reassure ------- and remind him to breathe.

If you see this:
Seizure has continued for 5 minutes.
Student appears to be in any distress.

Do this:
1. All seizures lasting 5 minutes requires EMS call and transport to hospital for evaluation.
   911 MUST be called at this time if the call has not been made already!
   2. Nurse may administer Diastat. If out in the community and no nurse or trained delegate is available, hand the Diastat to EMS and they may administer per Dr.’s orders.
   3. Notify parent of EMS transfer. ------- is the hospital of choice.

If any questions or concerns arise, always consult with the school nurse.

Revised -2009, Paula Sears R.N.