SPECIAL SCHOOL DISTRICT - EMERGENCY CARE PLAN

Emergency Care Plan effective _____ to _____ Review date _____

Student name_____ School year _____

Parent phone _____ Parent cell _____

Alternate contact (name & relationshp) _____ Phone _____

Primary physician (name) _____ Phone _____

STUDENT SPECIFIC DATA FOR CLASSROOM

If you see this:	Do this:

STUDENT SPECIFIC DATA FOR COMMUNITY

If you see this:	Do this:

Additional comments:

_____

_____

_____ _____

School Nurse Phone

Rev. 1/28/05

SPECIAL SCHOOL DISTRICT
HEALTH SERVICES

Date_____

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 give immediately.

Student Photo

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/without 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/without 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: _____

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

Photo of student here

SSD Seizure Health Care Plan

NAME:		Seizure type:	
Brief history of seizures:			
Diastat: yes/no Order:_____ _____ PRN medicine: yes/no Order:_____ _____		Vagus nerve stimulator: yes/no Order:_____ _____ Ketogenic diet: yes/no _____ _____	
School:	Date of Birth:	Grade:	
Bus #	Doctor name/number:	Daily meds. at school	Date of last seizure:

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: _____

SPECIAL SCHOOL DISTRICT
HEALTH SERVICES

SPECIALIZED NURSING INTERVENTION OR TREATMENT

_____
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.

~~O~~rders 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

12110 Clayton Rd. * Town & Country, Missouri 63131 * 989-8100

SPECIAL SCHOOL DISTRICT
HEALTH SERVICES

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

12110 Clayton Rd. * Town & Country, Missouri 63131 * 989-8100

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

	Drug Name	Dose	Time
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

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
- Prescription number.
- Date prescription filled
- Specific instructions for administering
- Name of medication

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:

Quick Relief Medications	Dose/Frequency	When to Administer

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/
2. http://www.nhlbi.nih.gov/health/public/lung/asthma/asthma_actplan.htm

National Asthma Education and Prevention Program
NAEPP School Asthma Education Subcommittee

Is the Asthma Action Plan Working?
A Tool for School Nurse Assessment

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 wakening 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.

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

	Responsible Person/Site	Yes	No	N/A
Medical Administration				
• Does the student use correct technique when taking medication?	Home	☐	☐	☐
	School	☐	☐	☐
• Does the person administering the medication use correct technique?	Home	☐	☐	☐
	School	☐	☐	☐
Monitoring				
• Can the student identify his/her early warning signs and symptoms that indicate the onset of an asthma episode and need for quick-relief medicine?		☐	☐	☐
• Can the student identify his/her asthma signs and symptoms that indicate the need for help or medical attention?		☐	☐	☐
• Can the student correctly use a peak flow meter or asthma diary for tracking symptoms?		☐	☐	☐
• Are the student's asthma signs and symptoms monitored using a Peak Flow, verbal report, or diary?	Home	☐	☐	☐
o Daily?	School	☐	☐	☐
o For response to quick-relief medication?	Home	☐	☐	☐
	School	☐	☐	☐
o During physical activity?	Home	☐	☐	☐
	School	☐	☐	☐
Trigger Awareness				
• Have triggers been identified?		☐	☐	
• Can student name his/her triggers?		☐	☐	☐
• Can parents/caregivers list their child's asthma triggers?		☐	☐	
• Are teachers, including physical educators, aware of this student's asthma triggers?		☐	☐	
Trigger Avoidance				
• Are triggers removed or adequately managed?	Home	☐	☐	☐
	School	☐	☐	☐

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:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:_____

Student's reaction to seizure:_____

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

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

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:

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

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_____

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

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

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):

Seizure Type	*Length*	*Frequency*	*Description*

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?_____

BASIC FIRST AID: Care and Comfort Measures

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

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

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

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

_____

_____

_____

_____

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

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?

Medication	Date Started	Dosage	Frequency and time of day taken	Possible side effects

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

Medication	Dosage	Administration Instructions (timing* & method**)	What to do after administration:

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

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:_____, _____

EPILEPSY FOUNDATION®

Seizure Observation Record

SSD SEIZURE OBSERVATION RECORD

(adapted from Epilepsy Foundation 3/24/09) Form#SZ1

Student Name:				
Date & Time				
Seizure Length				
Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)				
Conscious (yes/no/altered)				
Injuries (briefly describe)				
Muscle Tone/Body Movements	Rigid/clenching			
	Limp			
	Fell down			
	Rocking			
	Wandering around			
	Whole body jerking			
Extremity Movements	(R) arm jerking			
	(L) arm jerking			
	(R) leg jerking			
	(L) leg jerking			
	Random Movement			
Color	Bluish			
	Pale			
	Flushed			
Eyes	Pupils dilated			
	Turned (R or L)			
	Rolled up			
	Staring or blinking (clarify)			
	Closed			
Mouth	Salivating			
	Chewing			
	Lip smacking			
Verbal Sounds (gagging, talking, throat clearing, etc.)				
Breathing (normal, labored, stopped, noisy, etc.)				
Incontinent (urine or feces)				
Post-Seizure Observation	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)

Diatsat 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.