Kodiak Island Borough School District

Siezure Care Plan

Optional Student Photo

EFFECTIVE DATE:	End Date:
STUDENT'S NAME:	Date of Birth:
SEIZURE HEALTHCARE PROVIDER INFORMATION Name:	
Phone #: Fax #:	
SCHOOL: / Grade	School Fax:

Seizure Triggers:

- ☐ **Missed Medication**
- ☐ **Alcohol/ Drugs**
- ☐ **Lack of Sleep**
- ☐ **Flashing Lights**
- ☐ **Emotional Stress**
- ☐ **Menstrual Cycle**
- ☐ **Physical Stress**
- ☐ **Illness with high fever**
- ☐ **Missing meals**
- ☐ **Boredom**
- ☐ **Response to Specific Food_____**
- ☐ **Other (specify) _____**

Seizure Type	How Long it Lasts	How Often	Description
☐ Absence seizures (petite-mal)			A period of unconsciousness with a blank stare or what looks like daydreaming. The person may lose muscle control and make repetitive movements.
☐ Tonic-clonic or convulsive seizures (grand-mal)			The student will lose consciousness from the start of the seizure. The muscles will stiffen (tonic phase), causing him/her to fall to the floor. The extremities will then jerk and twitch rhythmically (clonic phase). Student may froth at the mouth. Breathing may be irregular. The person will regain consciousness slowly.
☐ Myoclonic Seizures			Consciousness and memory are not impaired. Muscle jerks may occur in parts or all of the body.

FIRST AID FOR ANY SEIZURE

- ☐ **STAY** calm, keep calm, & **BEGIN TIMING SEIZURE**
- ☐ Keep me **SAFE**- remove harmful objects, don't restrain, & protect head
- ☐ **SIDE**- turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe Magnet from VNS
- ☐ Write down what happens_____
- ☐ Other_____

When to Call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be

Rescue Medication Orders:

WHEN and WHAT to Do
If seizure (cluster, # of seizures, or length/ minutes seizure:_____ Name of Med/ Rx:_____ How much to give (dose):_____ How to give (route):_____
If seizure (cluster, # of seizures, or length/ minutes seizure:_____ Name of Med/ Rx:_____ How much to give (dose):_____ How to give (route):_____
If seizure (cluster, # of seizures, or length/ minutes seizure:_____ Name of Med/ Rx:_____ How much to give (dose):_____ How to give (route):_____

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CARE AFTER SEIZURE

What type of help is needed? (Describe)_____

When is student able to resume normal activity?_____

SPECIAL INSTRUCTIONS

First Responders: _____

_____

Emergency Department: _____

_____

DAILY SEIZURE MEDICATIONS

Medication Name	Total Daily Amount	Amount of Tab/ Liquid	How Taken (time of each dose & how much)

OTHER INFORMATION:

Important Medical History_____

Allergies_____

☐ **YES** ☐ **NO** **Does this student have a vagal nerve stimulator (VNS) or other device?**
Please describe use: _____

☐ **YES** ☐ **NO** **Is this student allowed to participate in usual school activities including physical education?**

☐ **YES** ☐ **NO** **Does this student require any other special considerations or safety precautions?**
Please explain: _____

Medical Provider:	**NPI:**	**Phone:**
Signature:	**Email:**	**Date:**

PARENT / GUARDIAN AGREEMENT & AUTHORIZATION

I authorize the school nurse to train school staff using a standardized curriculum to administer the medication(s) to my child according to this care plan. I understand that, in the absence of the nurse, other trained Kodiak Island Borough School District personnel may administer this medication. I agree to defend and hold school district employees harmless from any liability for the results of the care, or the way it is administered. I agree to defend and indemnify the school district and its employees for any liability arising out of these arrangements. If I wish to be part of the staff training for my student, I will contact my school nurse to collaborate.

I request that the medication(s) selected and allergy/ anaphylaxis protocols listed on this plan be provided to my child. I will provide needed medications or supplies for care in school. I understand that prescription medication must be in the original pharmacy container labeled with the following information: student name, medication, dosage, route, administration time, ordering healthcare provider, pharmacy, date issued, and prescription number. I will notify KIBSD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and KIBSD as part of the provision of my child's care. I agree for the nurse to share health information with KIBSD staff on a need-to-know basis for my child's safety and to foster academic success. I understand that ANY remaining medication(s) will be disposed of at the end of the school year, unless I pick up the remaining medication(s) by the last school day, as indicated on the KIBSD school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)	DATE

☐ Reviewed by School Nurse ☐ Medication received from parent for school use.

Nurse Signature _____ **Date**_____

EPILEPSY FOUNDATION

Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child'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	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	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 & Comfort

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

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:

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 seizure:

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

Seizure Emergencies

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:

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

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 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 should be done when your child misses a dose? _____
19. Should the school have backup medication available to give your child for missed dose? ❒ YES ❒ NO
20. Do you wish to be called before backup medication is given for a missed dose? ❒ YES ❒ NO
21. 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 consideration or precautions that should be taken:

❒ General health _____ ❒ Physical education (gym/sports) _____
❒ Physical functioning _____ ❒ Recess _____
❒ Learning _____ ❒ Field trips _____
❒ Behavior _____ ❒ Bus transportation _____
❒ Mood/coping _____ ❒ 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

Dates _____
Updated _____

Parent/Guardian Signature _____ **Date** _____

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