WCSCC
WAYNE COUNTY SCHOOLS **CAREER CENTER**
Education at its Finest

Place Child's Picture Here

THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR and START FROM THE TIME IT'S SIGNED BY THE PHYSICIAN AND PARENT/GUARDIAN

Seizure Action Plan

School Year: _____ Grade/Class: _____

Student's Name: _____ Date of birth: _____

Address: _____ City: _____ Zip: _____

Physician Name (Printed): _____ Physician Phone: _____

Emergency Contact Information

1. Parent/Guardian: _____Phone: _____
2. Emergency Contact: _____Phone: _____
3. Emergency Contact: _____Phone: _____

When was your students most recent seizure: _____

Seizure Type: _____

Usual Length: _____How Often: _____

Precipitating Factor/Seizure Triggers/Warning Signs: _____

Does Student need to leave classroom after a seizure? YES___ NO___

Daily seizure medication, amount and how often taken: _____

BASIC FIRST AID WITH SEIZURES	**FOR TONIC-CLONIC (GRAND MAL) SEIZURE:**	**WHEN TO CALL 911**
• Stay Calm and remove bystanders • Track time (duration of seizure activity) Start time, End time • Keep child safe • Speak quietly and calmly to child • Do NOT restrain or attempt to stop movement • Do NOT put anything in mouth • Stay with child until fully conscious	• Follow basic first aid from above • Protect head • Place child on his/her side away from harmful objects (chairs, desks etc.) • Remove eyeglasses and any tight objects around the person's neck	• Tonic-Clonic seizure lasting longer than 5 minutes • Child has repeated seizures without regaining consciousness • Child is injured or has diabetes • Known injury occurred or suspected • Known drug overdose occurred or suspected • Child has difficulty breathing, heart rate, behavior doesn't return to normal • "As needed" treatments aren't working

See back for medication orders

Seizure Action Plan Continued Student's Name: _____

Medical Treatment prescribed for seizure emergencies

MEDICATION/TREATMENTS: **PHYSICIAN ORDERS**

Medication Name: _____

Dosage: _____Route: _____

When/Time to be Given: _____

Common Side Effects & Special Instructions: _____

_____

- **VAGUS NERVE STIMULATOR: How to Use:** Swipe magnet over device (device is located under the skin of upper left chest: remove the magnet, you may repeat every one or two minutes until the seizure resolves).

Green Zone-Less than 2 minutes	**Yellow Zone-2-5 minutes**	**Red Zone More than 5 minutes or if 2 or more consecutive seizures**
• Begin First Aid • Swipe VNS Magnet if ordered • Allow student to recover from seizure • Notify parent/guardian and return to class or to home as instructed by parent/guardian	• Continue First Aid • Call for help • Re-swipe VNS magnet • Allow student to recover from seizure • Notify parent/guardian and return to class or to home as instructed by parent/guardian	• Administer other medication if ordered • Continue First Aid • Notify parent/guardian • If seizure does not stop after medication **CALL 911**

AGREEMENT: PARENTS ARE RESPONSIBLE FOR PROVIDING ALL NECESSARY MEDICATION/TREATMENT TO THE CLINIC IN A TIMELY MANNER.

- I am requesting permission for my child named above to receive medication in accordance with this action plan. I will assume responsibility for safe delivery of the medication/drug to school. The medication must be brought to school in the container in which it was dispensed by the prescriber or licensed pharmacist.
- I will notify the school immediately if there is any change in the use of the medication or prescribed treatment. A revised action plan will need to be on file signed by the prescriber.
- I release and agree to hold the Board of Education, it's officials, and it's employees harmless from all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signatures: Represent agreement with the above Information/Action Plan

PARENT/LEGAL GUARDIAN: _____ Date: _____

HEALTHCARE PROVIDER SIGNATURE: _____Date: _____

SCHOOL NURSE: _____ _Date: _____

5/10
4/4/14
4/27/22