SUMTER COUNTY SCHOOLS HEALTH SERVICES
EMERGENCY ACTION PLAN – SEIZURES
(To be completed by Registered Nurse) **SCHOOL** _____
Length of time condition has existed_____.

Grade _____ **Teacher** _____ **Date Initiated** _____
Grade _____ **Teacher** _____ **Date Reviewed** _____
Grade _____ **Teacher** _____ **Date Reviewed** _____
Date Discontinued _____

Name: _____ **DOB:** _____
Parent #1: _____ **Phone #1:** _____ **Phone #2:** _____
Parent #2: _____ **Phone #1:** _____ **Phone #2:** _____
Emergency Contact #1: _____ **Phone:** _____
Emergency Contact #2: _____ **Phone:** _____
Physician Name: _____ **Phone:** _____
Specialist Name: _____ **Phone:** _____

Allergies to:

☐ Food _____ ☐ Medication _____
☐ Insect's _____ ☐ Other _____

NON CONVULSIVE SEIZURE Description: Sudden disturbance in the electrical activity in the brain. This disturbance affects only one part of the brain and may or may not disrupt consciousness.

CONVULSIVE SEIZURE Description: Sudden disturbance in the electrical activity in the brain. This disturbance affects the whole brain and results in loss of consciousness.

Triggers that may cause a seizure:_____

***Student's usual signs/symptoms of seizure:**_____

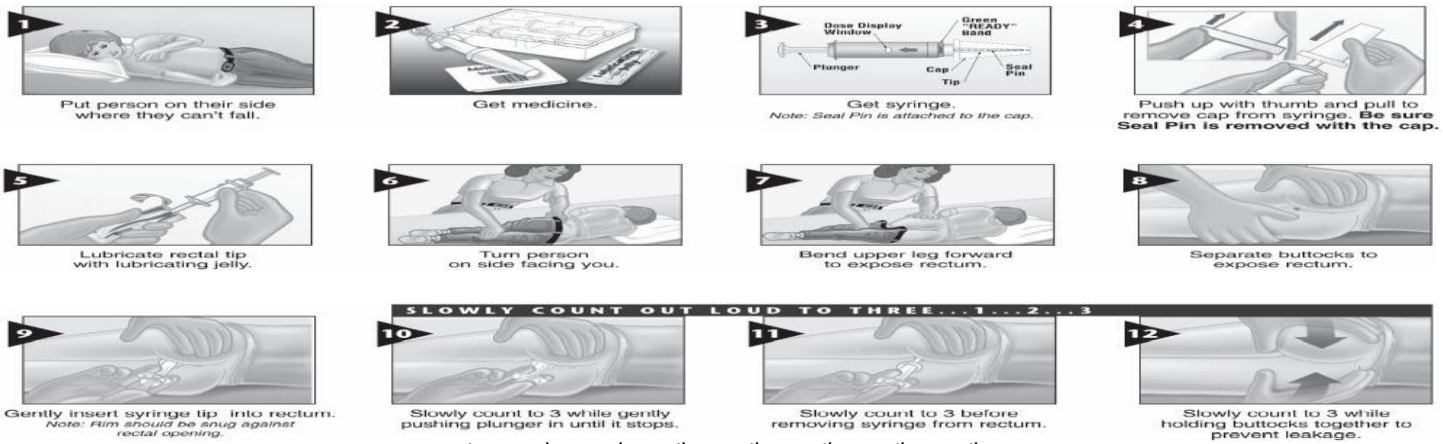
Medications at School	Medication Storage Location
Diastat Accudial _____mg	☐ Clinic/Health room
Vagal Nerve Stimulator: Give ____ swipes. Wait ____ min. between swipes	☐ Classroom
	☐ Self-Carry/Backpack
	☐ Other: magnet located_____

Potential Emergency Situations – Types of Seizures

Petit Mal/Absence Clonic	**Partial Complex**	**Gand Mal/Tonic-**
- Stares	- Unable to talk	- Convulsions
- Repetitive blinking or chewing	- Muscle twitching on on one side of body	- Loss of bowel and bladder function
- Appears dazed, Unresponsive	- Picks at things or clothings	- Loss of consciousness
		- Falls or collapses

SYMPTOMS OF A SEIZURE EMERGENCY
- Seizure lasting 5 minutes or more
- Repeated seizures without gaining consciousness
- Breathing problems

MANAGEMENT OF SEIZURE EMERGENCY
- CALL 911
- Notify school nurse and administration
- Protect from injury
- DO NOT RESTRAIN other than to prevent injury.
- DO NOT PUT ANYTHING IN THE MOUTH
- Keep airway open
- Turn student on side
- Loosen any constricting cloths around neck
- Administer Diastat if ordered by physician
- Notify parent.
- Monitor student for type of seizure and duration of seizure
- Other _____



Sent Copies To: Teacher: ___Homeroom ___ 1st ___ 2nd ___ 3rd ___4th ___ 5th ___ 6th ___ 7th ___ 8th ___ Clinic ___PE ___Art ___Music
___Cafeteria ___ Bus Driver ___School Nurse Coordinator/Supervisor ___Library ___Coach/PE ___Computer Lab ___Other

Student Name _____ **DOB** _____

*** As parent/guardian by signing this Health Care Plan, I authorize designated Sumter County School personnel, Sumter County Health Department School personnel, and any other contracted health care agencies to provide emergency care for my child and/or to share or exchange medical information as necessary to support the education and continuity of care of my child. I also give permission for the Sumter County Schools to share this information with faculty/staff who are directly involved in my child's education.**

Parent Signature _____ **Date** _____

☐ **Obtained via telephone interview with parent** **School Year** _____

_____ _____

Nurse Signature and Date **School Health Tech Signature and Date**

_____ _____

Teacher Signature and Date **Teacher Signature and Date**

_____ _____

Other Faculty/Staff (Specify) and Date **Other Faculty/Staff (specify) and Date**

***YEAR 2 REVIEW: Update to Individual Emergency Action Plan** **School Year** _____

Status determined by:

- ☐ **Person-to-person interview**
- ☐ **Telephone interview**
- ☐ **Update letter**
- ☐ **No changes to current plan**

_____ _____

Parent Signature and Date **Nurse Signature and Date**

_____ _____

Teacher Signature and Date **Other Faculty/Staff (Specify) and Date**

***YEAR 3 REVIEW: Update to Individual Emergency Action Plan** **School Year** _____

Status determined by:

- ☐ **Person-to-person interview**
- ☐ **Telephone interview**
- ☐ **Update letter**
- ☐ **No changes to current plan**

_____ _____

Parent Signature and Date **Nurse Signature and Date**

_____ _____

Teacher Signature and Date **Other Faculty/Staff (Specify) and Date**

***Note: 1. Significant changes to the plan of care requires a new Individual Emergency Action Plan be completed.**
2. At the beginning of the 4th school year based on the initial date of this plan a new EAP will be written.