



# BUCKEYE LOCAL SCHOOL DISTRICT

BUCKEYE LOCAL BOARD OF EDUCATION

3044 Columbia Road

Medina, Ohio 44256

Phone: 330-722-8257

## Seizure Action Plan

Student's Name:	School/Grade:
Date of Birth:	Contact Teacher:
Parent/Guardian Name:	Phone (Family):
Address	
Physician:	RN:
Emergency Number:	

Seizure Type: \_\_\_\_\_

Date: \_\_\_\_\_

### Medications:

\_\_\_ Diastat: \_\_\_ mg rectally as needed for a seizure lasting more than \_\_\_ mins.

Or \_\_\_\_\_ or more seizures in \_\_\_\_\_ hrs.

\_\_\_ Versed \_\_\_ mg intranasally as needed for a seizure lasting more than \_\_\_ mins.

Or \_\_\_\_\_ or more seizures in \_\_\_\_\_ hrs.

Additional Directions \_\_\_\_\_

\_\_\_ Use VNS (vagal nerve stimulator) magnet \_\_\_\_\_

\_\_\_ Other: \_\_\_\_\_

Signs/Symptoms: \_\_\_ staring \_\_\_ unresponsiveness \_\_\_ confusion

\_\_\_ jerking or twitches \_\_\_ shaking \_\_\_ falling

\_\_\_ picking or lip smacking \_\_\_ whole body convulsions (grand mal)

<p><b>STAY CALM- you <u>cannot</u> stop a seizure</b></p> <ul style="list-style-type: none"> <li>• Note time seizure began (if possible)</li> <li>• Keep child safe</li> <li>• Call office for RN and give location and name of student</li> <li>• Guide child to floor, position student on their left side to keep airway open</li> <li>• Do not restrain or attempt to put anything in student's mouth</li> <li>• Loosen any tight clothes</li> <li>• Remove eyeglasses</li> <li>• Move objects/furniture away from child that they may bump</li> <li>• Stay with child until help arrives or seizure stops</li> <li>• If loss of bowel or bladder control, cover the child for privacy</li> </ul>	<p><b>For Staring (Absence or Complex Partial) Seizure:</b></p> <ul style="list-style-type: none"> <li>• No action needed if brief periods of staring, mumbling, or shaking of arms or legs</li> <li>• No action needed if student has brief periods of dazed or zoned out</li> <li>• Speak quietly and calmly</li> <li>• Guide the student gently away from any possible source of injury</li> <li>• Stay with the student until the seizure ends</li> <li>• Comfort the student and allow to rest afterward if needed.</li> </ul>
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**CALL 911 and tell them “a student is having a seizure” if:**

- Seizure lasts longer than \_\_\_\_\_ minutes.
- Child has \_\_\_\_\_ seizures in \_\_\_\_\_ minutes.
- Child has an injury or severe seizure.

**Action after a seizure:**

_____ <b>Permit child to rest in clinic</b>	_____ <b>Permit child to return to class</b>
_____ <b>Provide a change of clothing as needed</b>	_____ <b>Contact parent/legal guardian</b>

I am in agreement with this plan of care and understand it will be shared as needed with members of the school staff to safeguard and promote the health of the student listed above while at school. I will notify the school immediately if: 1) the health status of the student listed above changes, 2) we change physicians, or 3) there is a change or cancellation of the physician's orders.

Parent/Legal Guardian \_\_\_\_\_  
Date \_\_\_\_\_

Registered Nurse \_\_\_\_\_  
Date \_\_\_\_\_

## MEDICAL REVIEW

I have reviewed the attached Seizure Action Plan for \_\_\_\_\_ AND:

\_\_\_\_\_ I approve the Action Plan as written.

\_\_\_\_\_ I approve the Action Plan with the attached amendments.

\_\_\_\_\_ I do not approve of the Action Plan as written, and substitute orders are attached.

Physician \_\_\_\_\_

Date \_\_\_\_\_

### **Other Recommendations:**

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Copies to:

Board Office       Bus Garage       Teacher       Other \_\_\_\_\_