BOYERTOWN AREA SCHOOL DISTRICT
EMERGENCY ACTION PLAN FOR SEIZURES

Student's Name: ____ Date of Birth: _____________
Parent/ Guardian Emergency contact #1_____________________Phone_____________________
Parent/Guardian Emergency contact #2______________________Phone____________________
Seizure Type______________________________Length____________________Frequency____
Description____Date of last seizure______________
Possible triggers that should be avoided____
Student's response after a seizure____
Treating Physician: ____
Phone number: _____________________________ Date last seen: ______________
Current Medications used at home? Yes or No. If yes__________________________________
Emergency Medication to be administered at school? Yes or No
Name of medication____
Dose ___________________________________Time/ Frequency_________________________
Side effects and special instructions____
____

Accommodations or restrictions at school? Yes No. If yes, please provide a doctor's note with these accommodations____

EMERGENCY ACTION PLAN:
District First Aid Procedures:

1. DO NOT MOVE STUDENT until seizure subsides. Do not restrain, prevent self-injury
2. Turn student to side or turn head to prevent aspiration.
3. Stay with student until fully conscious.
4. Do not put anything in mouth and monitor breathing
5. Record time and details of seizure activity.
6. For a seizure: Call 911 when: the seizure lasts for more than 5 minutes, the student has no history of seizure, slow recovery following a seizure, a second seizure occurs, repeated seizures without regaining consciousness, difficulty breathing or injury that occurred from the seizure. (Please note, should an ambulance be called we have no authority to direct them to a specific hospital)

Please indicate below any additional emergency procedures you would like us to follow for your child:
____
____

Does the student have a Vagus Nerve Stimulator? Yes or No If yes, describe magnet use____
____

Physician
Signature____Date_______

A Parent/ guardian signature are required: Please complete back side of this Action Plan

I, the parent/guardian of ______________________________ request that the Boyertown Area School District nurse administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Boyertown Area School District and its Board of Directors and all employees unless the District is negligent with regard to any claim for injury in connection with administration of the prescribed medication.

Additionally, I agree to hand deliver the medication to the nurse's office in the original pharmacy or physician labeled container. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give permission for the school and physician to communicate regarding this medication and medical condition.

PARENT /GUARDIAN SIGNATURE_____________________________________DATE___________

I give permission for the release and exchange of information between the nursing staff and my child’s health care provider concerning my child’s health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

DATE_______PARENT/GUARDAN SIGNATURE_____________________________________

***REMINDER: All Action Plans and Medications require a yearly renewal while your child is under School Jurisdiction.**

Individualized Health Plan for Seizures

Assessment: Student’s seizure may cause student to fall in hallway or classroom and sustain bodily injury. Student has symptoms of drowsiness post seizure activity.

Nursing Diagnosis: Potential for injury due to sudden and unexpected loss of consciousness.

Goal: Student will exhibit no evidence of physical injury. Student will demonstrate safety measures, if applicable, when aura presents prior to seizure in order to prevent injury.

Nursing Interventions: Protect student during a seizure and follow ECP. Encourage student to position self in a safe position if aura presents and request assistance. Remove remaining students from classroom or hallway. During seizure activity, make student safe; ease to the floor, remove all furniture, loosen tight clothing, and don’t put anything in student’s mouth. Do not restrain student, allow seizure to take place and turn on side if vomiting occurs. Monitor ABC’s vital signs and duration of seizure activity. Allow student to rest until fully oriented. Follow ECP and administer medications as ordered by physician. Call 911, if needed