COLUMBUS COUNTY SCHOOLS

817 Washington St., Whiteville, NC 28472
(910) 642-5168

NAME: _____

SEIZURES
EMERGENCY ACTION PLAN

SYMPTOMS: ABSENCE (PETIT MAL): Brief loss of consciousness, minimal or no alteration in muscle tone, usually able to maintain postural control, frequently has minor movements or twitching, often mistaken for inattention.

TONIC-CLONIC (GRAND MAL): Loss of consciousness, child falls to floor or ground, breathing may stop for a moment, arms and legs may become rigid and move in rhythm with face, may be incontinent of urine and/or feces, may last several minutes, may want to sleep afterwards.

INTERVENTIONS:

1. **Stay with child during and after seizure. Note duration of seizure and type of body movement during seizure episode.**
2. **Assist to horizontal position if loss of consciousness occurs. Remove glasses, loosen clothing around neck.**
3. **Turn on side as soon as able.**
4. **Clear area around child to prevent injury.**
5. **DO NOT RESTRAIN MOVEMENT OR PLACE ANYTHING IN MOUTH.**
6. **Monitor breathing and begin rescue breathing if breathing does not resume spontaneously.**
7. **If seizure lasts more than 5 minutes or student has one seizure after another without waking, call 911 and transport to _____ Hospital.**
8. **When seizure is over, allow child to rest and always notify parents.**
9. **Notify school nurse.**
10. **Additional information.**

In order to make sure my child's special health needs are met, I understand and agree that the information will be shared with school staff/other personnel on a need to know basis in order to provide appropriate care. I understand and agree that the school nurse may contact my child's doctor about this condition.

PARENT/GUARDIAN SIGNATURE _____ DATE_____

NURSE_____DATE_____

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SCHOOL SEIZURE RECORD

STUDENT NAME_____SCHOOL_____TEACHER_____GRADE/YEAR_____

PARENT/GUARDIAN_____PHONE_____PHONE_____

HEALTH CARE PROVIDER_____PHONE_____

1. **Does your child wear a "medic alert" bracelet? Yes No**
2. **What type of seizures does your child have and how often do they occur?**
3. **Describe your child's symptoms during and after the seizure episode.**
4. **Does your child have an aura or warning of seizure coming? Is she/he able to notify anyone that a seizure is coming?**
5. **Name medications taken. How often and how much?**

   At Home:

   At School:
6. **Does your child suffer any side effects to these medications? Please list:**
7. **Name any activities in which your child CANNOT participate (DOCTOR'S NOTE REQUIRED)**
8. **What steps do you want school personnel to take if a seizure should happen?**

PLEASE NOTE: If medications are to be taken at school, they must have a prescription label from the doctor, and a medical authorization form must be completed by the doctor and kept at school. Students are NOT allowed to transport medicines. Medical forms may be obtained from the office, and are renewed each year for each medication.

PLEASE READ THE EMERGENCY ACTION PLAN FOR SEIZURES ON THE REVERSE SIDE, AND ADD ANY ADDITIONAL INFORMATION.

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Request for Medication Administration in School

To be completed by physician or licensed primary care provider:

Name of Student:_____DOB:_____
School/Grade/Teacher_____
Medication: (each medication is to be listed on a separate form)_____
Prescribed for:_____Dosage and Route:_____
Time(s) daily medication is to be given: a.m._____ p.m._____
Time(s) to give PRN(as needed) medication: _____
To be given from: (date)_____ to/through:_____
Significant Information (include side effects, toxic reactions, reactions if omitted, take with/without food, etc.)_____

_____

Contraindications for Administration (reasons not to give):_____
If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact me _____ at my office_____
print name phone number

b. Take child immediately to the emergency room at _____

FOR SELF-ADMINSTRATION -

☐Student has demonstrated ability and understands the use of and may carry and self-administer asthma medication, diabetes medication, or medicine for anaphylactic reactions.
[Asthma/allergic reaction ☐MDI (*Metered Dose inhaler) ☐MDI with spacer *
☐Epinephrine ☐diabetes –insulin ☐ diabetes – glucose]
*Parent/guardian must provide an extra inhaler/epinephrine injector/source of glucose to be kept at school in case of emergency
A written statement, treatment plan and written emergency protocol developed by the student's health care provider must accompany this authorization form in accordance with requirements stated in G.S. 115C –375.2 ***The student also must have a self-medication agreement on file****.*

Date_____ Physician's Signature_____

To be completed by parent:

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for the school year, unless revoked.
I will furnish all medication for use at school in a container properly labeled by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

_____ _____ _____ _____
Parent or Guardian's Signature Telephone Number Date

(School Use Only)
Name and title of person to administer medication (unless self-administered)_____

Approved by_____ _____
Principal's Signature Date
Reviewed by _____ _____
School Nurse's Signature Date