

Seizure Action Plan & Medical Alert Information Care and Protocol

Student's Name _____ Date of Birth _____

This form is a communication tool for use by parents/guardians and the student's most responsible practitioner (MRP) to document and share information with the school in order for school staff to provide seizure care at school. Please review and update this form yearly or sooner if the student has a seizure at school or if there have been any changes in the student's condition and/or treatment.

Instructions for completion of this form:

Parent/guardian to complete all orange sections	MRP to complete all green sections	School to complete all blue sections
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 SAP Start Date: _____ SAP Expiry Date: June 30th, 20 _____ SAP Review Date(s): _____

NOTE: If the SAP start date is after May 1st, the SAP may be set to expire on June 30th of the following year
PART 1: PARENT/GUARDIAN to fill in this information

Name of Student:	Date of Birth:		Care Card Number:	Date Plan Initiated:
School:	School Year:		Grade/Division:	Teacher:

CONTACT INFORMATION: Please indicate who is to be called first and at which number

Parent/Guardian 1: <input type="checkbox"/> Call First	Name: _____			
	<input type="checkbox"/> Cell Number:	<input type="checkbox"/> Work Number:	<input type="checkbox"/> Home Number:	<input type="checkbox"/> Other Number:
Parent/Guardian 2: <input type="checkbox"/> Call First	Name: _____			
	<input type="checkbox"/> Cell Number:	<input type="checkbox"/> Work Number:	<input type="checkbox"/> Home Number:	<input type="checkbox"/> Other Number:
Other/Emergency:	Name: _____			Relationship: _____
	<input type="checkbox"/> Cell Number:	<input type="checkbox"/> Work Number:	<input type="checkbox"/> Home Number:	<input type="checkbox"/> Other Number:
MRP/Neurologist	MRP (name): _____		Phone Number: _____	

SEIZURE INFORMATION:

Describe what your child's seizures (single seizures or cluster seizures) look like so the non-medical school staff can recognize them.	_____
Describe how long your child's seizures normally last.	_____
Describe any auras (warning signs) that your child is going to have a seizure.	_____
Describe any triggers that may make a seizure more likely (e.g., illness, lack of sleep).	_____
Describe how your child usually behaves after a seizure.	_____
When was the last time your child had a seizure rescue medication?	_____

PART 2A: PARENT/GUARDIAN and SCHOOL to fill in this information
Signature(s) for After the Parent/Guardian Information Sharing Session with the School-Based Team

By signing below, I/we _____ confirm that I/we have reviewed the information in

Parent/guardian name(s)

this Seizure Action Plan and Medical Alert Information form with my child's school-based team on _____.

Date _____

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date: _____

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date: _____

PART 2B – SCHOOL to fill in this information (School Based Team Information)

School Based Team Lead or School Administrator: _____

Non-medical school staff who attended the parent information session and NSS Seizure Rescue Intervention Training (if applicable).

Non-Medical School Staff Name	Date of attendance at parent/guardian information session with school-based team	Date of attendance at NSS Seizure Rescue Intervention Training (If applicable)

PART 3: MRP to fill in this information

 If applicable, list any daily anti-seizure scheduled medication(s) needed at school (that **cannot** be scheduled before/after school):

Medication	Dosage	Frequency	Time of day to be taken at school	Comments

I, the undersigned MRP agree that the: (MRP to tick all and sign)

- student's seizure care can be safely managed in the school setting as per the care and protocol below.
- care and protocol orders for the school setting are the same that have been prescribed for the home/other community contexts.
- parent/guardian has been trained in the ordered seizure rescue intervention(s) (if applicable) and is capable of administration in the absence of a health care provider.
- parent/guardian can communicate with the non-medical school staff about the care and protocol steps below.

I, the undersigned MRP understand that: (MRP to tick only if applicable)

- the seizure rescue intervention orders I ordered below are different than the BCCH standard orders for seizure rescue.

Prescriber Name: _____ BC College # or BCCNM Registration # _____

Prescriber Signature: _____ Clinic Phone Number: _____ Date: _____

PART 4: PROTOCOL FOR SCHOOL STAFF TO FOLLOW – PARENT/GUARDIAN AND MRP to fill in this information

If the student has a seizure at school, follow the steps below. Note that not all steps will be applicable for all students.

Step	Steps to be Followed by School Staff During a Seizure	Who Fills in Each Step
STEP 1	<p>At the start of the seizure:</p> <ul style="list-style-type: none"> a) Stay calm, stay with the student, and provide reassurance. b) Call for help from people around you. c) Time the seizure. d) Keep student safe from injury. <ul style="list-style-type: none"> • Protect head, put something under head, remove glasses, clear area around student of hard or sharp objects. • Do not restrain. • If possible, ease student to the floor and position on side. If the student is in wheelchair/stander/walker, they may remain in their mobility device, unless their airway is blocked. • Do not put anything in student's mouth. e) Keep airway open. Watch breathing. f) Other steps that need to be taken in school if student has a seizure: <ul style="list-style-type: none"> • _____ • _____ 	Parent/ guardian to fill in this information
STEP 2	<p>If student has a seizure at school, the student: (tick one)</p> <p><input type="checkbox"/> <u>does not</u> require any seizure rescue intervention (beyond first aid), GO TO STEP 4 on the following page.</p> <p><input type="checkbox"/> <u>requires</u> a seizure first aid and seizure rescue intervention(s), GO TO STEP 3 below.</p>	
STEP 3	<p>If the student has a seizure at school:</p> <p><input type="checkbox"/> Swipe the VNS once at onset of seizure. If seizure does not stop, swipe once every ____ seconds to a maximum of ____ times. If seizure has not stopped after ____ minutes, <input type="checkbox"/> provide rescue medication as per below <input type="checkbox"/> call 911</p> <p><input type="checkbox"/> If the VNS has already been swiped and seizure stopped, but the student seizes again while waiting for parent/ambulance, VNS: <input type="checkbox"/> may not be used again OR <input type="checkbox"/> may be swiped again (as per above) ____ minutes after the last swipe.</p> <p><input type="checkbox"/> If student has a single seizure that lasts longer than ____ minute(s) OR OR <input type="checkbox"/> If student has more than ____ seizures in ____ minutes (cluster seizures)</p> <p><input type="checkbox"/> If student has a single seizure that lasts longer than ____ minute(s) OR OR <input type="checkbox"/> If student has more than ____ seizures in ____ minutes (cluster seizures)</p>	MRP to fill in this information MRP must also complete and sign PART 3 above MRP please round order for midazolam to the nearest 0.0 or 0.5 mL

STEP 4	<p>If the student has a seizure at school, call 911 (tick at least one):</p> <p><input type="checkbox"/> as soon as seizure starts.</p> <p><input type="checkbox"/> if seizure has not stopped after _____ minutes</p> <p><input type="checkbox"/> if seizure has not stopped _____ minutes after rescue intervention was given</p> <p><input type="checkbox"/> Other: _____</p> <p><input checked="" type="checkbox"/> if the student does not completely recover or return to their usual self after the seizure event.</p> <p><input checked="" type="checkbox"/> If the student is injured during the seizure.</p> <p><input checked="" type="checkbox"/> if the student has diabetes.</p> <p><input checked="" type="checkbox"/> if the student has breathing difficulties or looks grey or blue (cyanotic) after the seizure.</p> <p><input checked="" type="checkbox"/> if the student has breathing difficulties or looks grey or blue (cyanotic) after the seizure rescue intervention.</p> <p><input checked="" type="checkbox"/> if the seizure occurs in water.</p> <p><input checked="" type="checkbox"/> if it is the students first time having a seizure.</p> <p><input checked="" type="checkbox"/> as soon as the rescue medication is given if this is the first time the student is getting the rescue medication.</p>	MRP to fill in this information
STEP 5	<p><i>If the student has a seizure at school, call parent/guardian: (tick one)</i></p> <p><input type="checkbox"/> at onset of seizure.</p> <p><input type="checkbox"/> If seizure has not stopped after _____ minutes</p> <p><input checked="" type="checkbox"/> If seizure rescue medication is given as parent/guardian will need to pick up student from school within 30 minutes. If parent/guardian does not arrive in 30 minutes, call 911.</p> <p><input checked="" type="checkbox"/> Other; please specify: _____</p>	Parent/guardian to fill in this information
STEP 6	<p><i>Once the student's seizure stops:</i></p> <ol style="list-style-type: none"> Stay with the student until they are fully awake. Reassure the student. Reorient student to their surroundings. Allow the student to rest. Keep the environment calm and quiet. Do not give the student any food or drink until they are fully recovered. Call parent/guardian if you have not already called them. Other student specific needs: (e.g., Student will need to leave the classroom. Student will need to lie down.) <ul style="list-style-type: none"> • _____ • _____ 	Parent/guardian to fill in this information
STEP 7	<ol style="list-style-type: none"> Share this seizure action plan with the Emergency Medical Services (i.e., Paramedics) when they arrive. Give Emergency Medical Services Paramedics a report of what happened and the care the student received. 	
STEP 8	<p>Record the seizure information on the Seizure Log located on the last page of this Seizure Action Plan, and return the completed form to the school administration.</p>	
STEP 9	<p>School and parent/guardian and/or MRP to review the SAP and make changes if needed. Parents/guardians may make changes in the orange sections, the school may make changes to the blue sections, the MRP may make changes in the green sections. The family will share with the school/school staff any changes made to the plan, and the school will submit a new Request for NSS Training form if the MRP has ordered (1) a change the type of rescue intervention/medication (e.g. midazolam to lorazepam or the addition of a VNS) or (2) a change in route of midazolam administration (i.e. buccal to intranasal, or intranasal to buccal).</p>	

Seizure Action Plan & Medical Alert Information

Seizure Log

Student's Name _____

Date of Birth _____

Seizure Log

Describe what the seizure looked like (include any changes in student's muscle tone, arm/body movements, colour, breathing pattern, loss of bowel/bladder control):			
How long did the seizure last?			Where did seizure occur (location)?
Care/treatment provided: (if rescue medication given, record name of individual that did the double-check)			
Time parent called:	Time started:	Comments:	Time 911 called:
Did student return to usual self after the seizure? <input checked="" type="checkbox"/> Y <input type="checkbox"/> N			
Recorder's Name:		Initials:	
Date:	Time started:		
Describe what the seizure looked like (include any changes in student's muscle tone, arm/body movements, colour, breathing pattern, loss of bowel/bladder control):			
How long did the seizure last?			Where did seizure occur (location)?
Care/treatment provided: (if rescue medication given, record name of individual that did the double-check)			
Time parent called:	Time started:	Comments:	Time 911 called:
Did student return to usual self after the seizure? <input type="checkbox"/> Y <input checked="" type="checkbox"/> N			
Recorder's Name:		Initials:	
Date:	Time started:		
Describe what the seizure looked like (include any changes in student's muscle tone, arm/body movements, colour, breathing pattern, loss of bowel/bladder control):			
How long did the seizure last?			Where did seizure occur (location)?
Care/treatment provided: (if rescue medication given, record name of individual that did the double-check)			
Time parent called:	Time started:	Comments:	Time 911 called:
Did student return to usual self after the seizure? <input type="checkbox"/> Y <input checked="" type="checkbox"/> N			
Recorder's Name:		Initials:	