Mequon Thiensville SCHOOL DISTRICT

Emergency Care Plan – Seizures

Student Name: _____

Birthdate: _____

Teacher/Grade: _____

☐ **Oriole Lane Elementary:** Phone: (262) 238-4220 Fax: (262) 238-4250
☐ **Wilson Elementary:** Phone: (262) 238-4600 Fax: (262) 238-4662
☐ **Donges Bay Elementary**: Phone: (262) 238-7920 Fax: (262) 238-7970
☐ **Steffen Middle School:** Phone: (262) 238-4700 Fax: (262) 238-4740
☐ **Lake Shore Middle School:** Phone: (262) 238-5900 Fax: (262) 238-5633
☐ **Homestead High School:** Phone: (262) 238-5900 Fax: (262) 240-4157

EMERGENCY CONTACTS:

Name/Relationship	Phone Number(s)

MEDICAL CONTACTS:

Pediatrician Name/Address:	Pediatrician Phone:
Neurologist Name/Address:	Neurologist Phone:
Preferred Hospital:	**Diagnosis: History of Seizures**
Allergies:	**Medications:**

This student has a history of seizures. If a seizure should occur while student is in school, contact the school office and the student's parents. Follow the **Emergency Treatment for Seizures** protocol (attached).
A seizure is a sudden, uncontrolled episode of abnormal behavior related to abnormal electrical discharges in the brain.

Special Considerations for this Student:

Emergency Seizure Medicine Protocol (if prescribed for student):

1. Emergency medicine listed below.
2. Call E.R. Team, District Nurse, Parents, and 9-1-1 (in that order. If District Nurse is not available, call 9-1-1).

Medicine	Dose	Route	When to use

SCHOOL DISTRICT GOALS:

1. Keep student safe during seizure activity.
2. All staff will be aware of emergency treatment for seizure activity.
3. Document and notify District Nurse, Parents, and Building Administrator of any seizure activity during the school day.

PHYSICIAN ORDER:

The above medication/procedure is to be administered/performed during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication/procedure and understand medication will be given by non-medically trained school personnel. The emergency medication order shall be effective for one school year unless discontinued or changed by me. I understand that the student's parents have authorized administration of the emergency medication as ordered in the designated situations. I agree that this medication is appropriate for use at school.

Physician Signature: _____ Date: _____

School District Nurse Signature: _____ Date: _____

Parent Consent on Reverse Side

PARENT/GUARDIAN CONSENT:

- I agree with the above emergency care plan for my child.
- I request and authorize that this medication be administered at school by school personnel.
- I understand that parent/guardian/responsible adult should deliver all medication to the school.
- I will supply medication in its original, updated, properly labeled container.
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing of any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- I give my permission to have my child's photo displayed on this form and the school critical health alert form.
- I understand that non-medically trained school personnel will give medication.
- I agree to hold the School District, its employees, and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.

_____ _____

Signature of Parent/Legal Guardian **Date**

_____

Printed Name of Parent/Legal Guardian

_____

Phone Number 1 **Phone Number 2**

Emergency Treatment for Seizures

During a seizure you might witness: eyes moving back and forth, staring with no eye contact, no awareness of surroundings, twitching or jerking of the extremities, drooling, sudden fall or drop to the floor, vomiting, urination, unusual behavior.

Management of a seizure is limited to preventing injury

- Stay calm. Track time
- Ease the student to floor and protect him/her from hazards.
- Turn student on his/her side
- Monitor breathing, airway, color of lips and skin.
- Do not restrain.
- Do not place anything into the mouth
- Loosen restrictive clothing
- Do not give fluids or food during or immediately after seizure
- Notify parent and school nurse

Most seizures are not medical emergencies. Stay calm.

Call 911 if:

- The seizure lasts more than 5 minutes or if one seizure follows another
- The student is not breathing
- The student is turning blue
- The student does not resume normal breathing after the seizure ends
- There is an obvious injury

Management after the Seizure

- Remain with the student. Reorient the student and explain what happened.
- Document the event (when, duration, observations, actions taken, who notified)
- Student may be sleepy or confused after a seizure; this is normal
- Allow student to rest under observation
- After the rest period, student may participate in normal activities.

Document all seizures on the seizure log:

Student:_____School:_____Your Name:_____

Date	Student's activity prior to seizure	Time seizure started	Time seizure ended	Brief description of the seizure activity	Student's condition after seizure	Who was notified