CENTRAL DECATUR
SEIZURE ACTION PLAN

Student name: **DOB:**
Diagnosis: **Allergies:**

Medications: **Other medications:**

Parent/Guardian: **Phone #**
Parent/Guardian: **Phone #**
Emergency Contact: **Phone #**

Physician: **Hospital:**

Condition: Seizure Disorder **Insurance:**

Usual treatment: Diastat Rectal Gel- kept in student backpack **LOCKER #** _____

Signs of Emergency: unawareness of surroundings/people, confusion, rigidity, eyes may roll, shaking, jerking of limbs.

ACTIONS FOR SCHOOL STAFF TO TAKE:

1. Inservice staff on Diastat Protocol yearly and PRN- Health Services to administer/delegate rectal Diastat per physician order.
2. Notify office in the event of a seizure (ext. 1815-north or 1400- south)
3. Note the time of when seizure activity started/ended.
4. Clear classroom and immediate area for student privacy/safety.
5. Position student on his/her side on the floor. Protect head from injury. Do not put anything in the child's mouth.
6. Administer medication as ordered for a seizure lasting three or more minutes, call 911, notify parent/guardian.
7. Stay with student until emergency help arrives.
8. Provide information about seizure to EMT's. Time seizure started/ended, medication/dose administered, symptoms of the seizure, possible triggers, and orientation after seizure.
9.

I have read the above plan and I have made changes that I felt necessary to the plan. I understand that the above plan will remain in place as long as my child is a student in the Central Decatur Community School District. I understand that it is my responsibility to notify the school nurse when changes to the plan need to be made. I give permission for the information in this plan to be shared with my child's teachers, Building Emergency Response Team, School Nurse's office staff and other school staff as deemed necessary.

This plan agreed to by :

Parent signature: _____ ***Date:*** _____

Plan written by: _____ ***Date:*** _____