Traders Point Christian Schools

(Parents complete pages 1-2 and Physicians complete pages 3-4)

SEIZURE Medical Action Plan (MAP)

Student's Name_____

Date of birth_____ **Age**_____ **Grade**_____

Child's picture; face only

CONTACT INFORMATION

Call First(Parent/Guardian)	**Try Second(Parent/Guardian**
Name:	**Name:**
Relationship:	**Relationship:**
Home:	**Home:**
Cell:	**Cell:**
Work:	**Work:**

Call Third (If a parent/guardian cannot be reached)

Name:_____ Relationship:_____

Address:_____

Phone:_____

Student's Name:_____

SEIZURE HISTORY

Seizure Type (please circle all that apply):

Generalized: **Tonic Clonic** (Grand Mal) **Atonic** (Drop Attacks) **Myoclonic Absence** (Petit Mal)

Partial: **Simple Complex** (Psychomotor/Temporal Lobe)

Other or description of seizure:_____

Date of last seizure:_____

How often do seizures occur:_____

How long does a typical seizure last:_____

Warning signs (Aura) or triggers if any, please explain:_____

_____

_____

Child on Ketogenic Diet. **YES** **NO**

Past history of surgery for seizures? **YES** **NO**

Any special considerations or safety precautions:_____

_____

_____

I agree to have the information in this medical action plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having seizures to better identify needs. I give permission for trained staff to administer any medication prescribed for seizure activity as ordered by the Physician and to contact the Physician for clarifications of orders, if needed.

Parent/Guardian (Printed Name):_____

Signature:_____

Date:_____
Student's Name:_____

Action if student has a seizure:

- **Track time**
- **Keep child safe**
- **Do not restrain**
- **Do not put anything in mouth**
- **Stay with child until fully awake**
- **Follow medical orders**
- **Document medical event**
- **Notify parents**

In addition for Tonic Clonic (Grand Mal) Seizure:

- **Keep airway open/watch breathing**
- **Protect head**
- **Turn child on side, if safely able to**
- **Follow medical orders**

General signs of a <u>SEIZURE EMERGENCY</u>:

- **Convulsion longer than 5 minutes**
- **Repeated seizures**
- **Injury**
- **History of Diabetes**
- **Breathing difficulties**
- **Seizure while in water**

<u>ACTION CALL 911</u>

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol

- ❑ **Administer Diastat® rectal gel for seizure lasting longer than ____ minutes.**

  Dose:_____

  Other:_____

- ❑ **No Diastat® ordered**

Does student have a Vagal Nerve Stimulator? YES NO
****If yes, please describe magnet use:_____**

Call 911 if (please check all that apply):

- ❑ **Seizure does not stop by itself within ____ minutes.**
- ❑ **Anytime Diastat® is given**
- ❑ **Only if seizure does not stop within ____ minutes after Diastat® administered.**
- ❑ **Other:_____**

Other instructions and/or orders:_____

_____

_____

Physician/Licensed Prescriber Name:_____

Phone Number:_____

Fax Number:_____

Signature:_____ Date:_____