

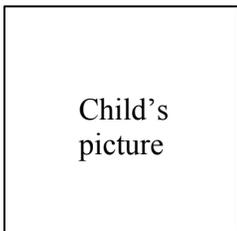


Oxford Community Schools SEIZURE Medical Action Plan (MAP)

Student's Name _____

Date of birth _____ School _____

Age _____ Grade _____ School Year _____



Child's
picture

Page one of this MAP is to be completed, signed and dated by a parent/guardian.
Page two of this MAP is to be completed, signed and dated by the treating physician/licensed prescriber.
Without signatures this MAP is not valid. The parent/guardian is responsible for supplying all medication & any other supplies required.

CONTACT INFORMATION

Call First

Try Second

Parent/ Guardian: Phone:	Name: _____ Relationship: _____ Home: _____ Cell: _____ Work: _____	Name: _____ Relationship: _____ Home: _____ Cell: _____ Work: _____
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Call Third (If a parent/guardian cannot be reached)

Name: _____ Relationship: _____
Address: _____ Phone: _____

SEIZURE HISTORY

Seizure Type (please check 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 _____

How long does a typical seizure last _____ **How often do seizures occur** _____

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

Age when seizures were diagnosed _____ **Date of last exam for this condition** _____

Student on ketogenic diet YES NO **Past history of surgery for seizures** YES NO

Student's reaction to seizure _____

Does student need to leave the classroom after a seizure? YES NO

If yes, describe process for returning to classroom _____

Notify parent immediately for all seizure activity YES NO

Other instructions _____

Any special considerations or safety precautions:

I agree to have the information in this two page 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 in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) I give permission for trained staff to administer any medication ordered for seizure activity and to contact the ordering physician/licensed prescriber for clarification of this plan if needed.

Date _____ Parent/Guardian _____

Signature _____

Bus # _____
Driver: _____
Transportation Office Use ONLY if needed
Route # _____
Medical File

Action if student has a seizure

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully awake
- Record seizure in a log

In addition for tonic-clonic (grand mal) seizure

- Keep airway open/watch breathing
- Protect head
- Turn child on side, if able to safely
- Follow medical orders (last box below)
- Follow directions of parent (page one of MAP)

General Signs of a Seizure EMERGENCY

- Convulsion (tonic-clonic/grand mal) **longer than 5 minutes** or per 911 instructions below in Order
- Student has repeated seizures without regaining consciousness
- Student is injured, has diabetes, or is pregnant
- Student has breathing difficulties, or normal breathing does not resume
- Student has a seizure in water
- Parents request emergency evaluation



Action

- Stay with the student until help arrives
- Call parent/guardian
- CPR if needed

CALL 911

Physician/Licensed Prescriber Order & Agreement with Protocol (as outlined in this 2 page plan)

Administer Diastat® rectal gel for seizure lasting longer than _____ minutes. **Dose** _____

Other instructions for Diastat® _____

No Diastat® ordered

Does student have a Vagal Nerve Stimulator YES NO (if YES, please describe magnet use)

Call 911 if: (please check and complete all that apply)

- † Seizure does not stop by itself within _____ minutes
- † Anytime Diastat is given
- † Only if seizure does not stop within _____ minutes after giving Diastat
- † Other directions or medications:

Physician/Licensed Prescriber's Name _____

Phone number _____ **FAX number** _____

Signature _____ **Date** _____