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APPENDIX B SEIZURE MANAGEMENT PROTOCOL

This plan should be completed by the student's health care team and parents/guardians. It should be reviewed annually with relevant school staff and copies should be kept in a place that is easily accessed by school staff.

Student's Name: _____ School Name: _____

Date of Birth: _____ Allergies: _____ Diagnosis:_____

Grade: _____ Principal:_____

Homeroom Teacher: _____Room Location:_____

CCAC Case Manager: _____ Telephone _____

Student's Doctor/Health Care Provider

Name:_____

Address: _____

Telephone: _____ Emergency Number: _____

Primary Contact Information

Parent/Guardian:_____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Regular Hours of Work: _____

Parent/Guardian: _____

Address: _____

Telephone: Home: _____ Work _____ Cell _____

Regular Hours of Work: _____

Other Emergency Contacts

Name: _____ Relationship: _____

Telephone: Home _____ Work _____ Cell _____

Notify parents/guardians in the following situations: _____

_____

Other Comments : _____

_____

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Seizure Activity

Triggers for seizure activity:

_____

_____

Intervention

Description of seizures (over the last 3-4 month time period):

_____

_____

_____

Action to be taken during seizure:

1). Note the time of onset
2). Position the student safely (_____).
3). Maintain an airway.
4). Talk to the student. Reassure them.
5). If any respiratory distress is evident, **call 911.**
6). **Call 911** if the seizure activity has not stopped after ___ minutes.
7). Make sure the student rests after the seizure.

*** on average, 911 is called after 5 minutes of seizure activity ***

Other actions specific to student that should be taken: _____

_____

Medication

Name of medication: _____

Dosage to be given: _____ When to be given: _____

Does the medication need to be given a second time? _____ If yes, please note the time intervals that it should be given: _____

Route of Medication: _____ Location of medication: _____

Who will give medication: _____

Signatures

This seizure management protocol has been reviewed by:

_____ _____
Student's Physician Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Principal/School Signature Date