Stark County Board of Developmental Disabilities

MED 2

Seizure Action Plan and Treatment Order

Student's Name: _____ Date of Birth: _____School:_____

Students's Address:_____

TO BE COMPLETED BY PARENT OR PHYSICIAN

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:_____

Student's reaction to seizure:_____

TO BE COMPLETED BY PHYSICIAN

This is to certify that the student named above is under my care for a seizure disorder and may need to have emergency medication administered by school personnel as indicated below. Begin Date:_____ End Date:_____

Specify Treatment:

[ ] DIASTAT (diazepam rectal gel) _____mg rectally prn for:
[ ] Seizure > _____minutes [ ] for _____or more seizures in _____hours
[ ] Use VNS (vagal nerve stimulator) magnet:_____
[ ] Intranasal Midazolam (Versed) [ ] 1ml vial (5mg/1ml) [ ] 2ml vial (10mg/2ml)
Total dosage to be administered _____mg/_____ml
Right Nostril _____ml Left Nostril _____ml
[ ] Other:_____

- Student to be picked up by parent/guardian after any emergency treatment during the program day.
- CALL 911 if:
  [ ] Seizure does not stop by itself or with VNS within _____ minutes.
  [ ] Seizure does not stop within _____minutes of giving DIASTAT or Intranasal Midazolam.
  [ ] Student does not start waking up within _____minutes after seizure is over.
  [ ] Any signs of cyanosis not returning to normal within _____ minutes.

Special Considerations & Safety Precautions; (re: program activities, sports, field trips, etc.)

[ ] None [ ] No use of power tools/power equipment [ ] No contact Sports [ ] No swimming
[ ] Other:_____

_____/_____ _____ _____ _____

Physician's Printed Name Signature (**NO STAMPS**) NPI# Date Office Phone

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby give the personnel of the Stark County Board of DD permission to administer the above prescribed medication to my son/daughter. Transportation staff will provide basic first aid, use VNS and notify site nurse of seizure activity. If the site nurse is not available, notify parent/provider. 911 will be called for a seizure emergency.

_____ _____ _____ _____

Student's Signature Date Parent/Guardian Signature Date

Medication Guidelines

1. This form must be completed and original returned to school nurse for emergency medications to be administered during the program day by school personnel.
2. This form must be signed by the physician and legal guardian.
3. If any order is changed, a new form is required. Notify the school nurse immediately.
4. Medications must be in a pharmacy labeled container. The label must include the student's first and last name, name and strength of medication, amount to be taken, route and time to be administered.

Diastat Procedure:

1. Washes hands if student's status permits
2. Activate EMS (911)
3. Request assistance if needed.
4. Assembles equipment
5. Explains procedure to student
6. Puts on gloves
7. Prepares filled syringe for use
8. Inspects for cracks in syringe tip
9. Lubricates syringe tip
10. Position student on side facing staff person
11. Bend upper leg & separate buttocks to expose rectum.
12. Insert syringe and administer medication while counting slowly to three
13. Slowly count to three again before removing syringe
14. Hold buttocks together while slowly counting to three
15. Keep student positioned on side facing staff person
16. Clean up procedure area.
17. Removes gloves and washes hands.
18. Documents medication, procedure and observations.
19. Reports any problems to nurse(s).

Basic Seizure First Aid:

- Stay calm & track time
- Keep individual safe and provide privacy
- Protect head
- Do not restrain
- Do not put anything in mouth
- Keep airway open/watch breathing
- Turn student on side
- Loosen constrictive clothing, especially at the neck and chest
- Stay with student until fully conscious
- Record seizure details
- Monitor airway, breathing and circulation