Seizure Management Emergency Care Plan

Identification

Child's Name Click here to enter text.	**Date of Birth:** Click here to enter text.	**Health Card Number:** Click here to enter text.	**MedicAlert® Number:** Click here to enter text.
Does your child carry an Emergency Health Services (EHS) Special Patient Protocol card with them? **Yes** ☐ **No** ☐			
Allergies: Click here to enter text.	**Medical Diagnosis(es):** Click here to enter text.		
Is your child aware of their diagnosis? **Yes** ☐ **No** ☐			
Does your child experience fears and/or anxiety related to their health care needs/medical diagnosis? **Yes** ☐ **No** ☐ ***If yes,*** please describe helpful coaching/support/management strategies: Click here to enter text.		Place Photo Here	
Medications required during school hours: N/A ☐ **1.** Click here to enter text. **2.** *Click here to enter text.* **3.** *Click here to enter text.*		**Location where medication is stored at the school (*refer to Board policy)*** **1.** Click here to enter text. **2.** Click here to enter text. **3.** Click here to enter text.	
Bus Driver(s) and Bus numbers(s) (if applicable):			
Morning Bus: Click here to enter text.		**Afternoon Bus:** Click here to enter text.	

Annapolis Valley Regional School Board | Cape Breton-Victoria Regional School Board | Halifax Regional School Board | Tri-County Regional School Board Students First | South Shore Regional School Board | Strait Regional School Board Excellence in Lifelong Learning | IWK Health Centre | nova scotia health authority

Identification

This plan has been shared with bus operators, and /or other school designated person(s) providing transportation
Yes ☐ **N/A** ☐

Does your child have any activity restrictions while at school?
Yes ☐ **No** ☐
***If yes*, please describe:**

Click here to enter text.

Emergency Contacts: Please prioritize 1,2,3, in the order the calls are to be placed:

Name	Relationship	Home Phone Number	Work Phone Number	Cell Phone Number	E-Mail
1.	**1.**	**1.**	**1.**	**1.**	**1.**
2.	**2.**	**2.**	**2.**	**2.**	**2.**
3.	**3.**	**3.**	**3.**	**3.**	**3.**

Identify the preferred method of communication, for <u>non-emergency</u> situations
- ☐**Phone call**
- ☐**Text**
- ☐**Email**
- ☐**Communication book/agenda**
- ☐**Other; please specify:** Click here to enter text.

Additional Information:
Click here to enter text.

Designated school staff with seizure management: *(to be completed by school staff)*

1. Click here to enter text.	**4.** Click here to enter text.
2. Click here to enter text.	**5.** Click here to enter text.
3. Click here to enter text.	**6.** Click here to enter text.

Designated school staff with rescue medication training if applicable: *(to be completed by school staff)*

1. Click here to enter text.	**4.** Click here to enter text.
2. Click here to enter text.	**5.** Click here to enter text.
3. Click here to enter text.	**6.** Click here to enter text.

General Seizure Information

Does your child have any warning signs/pre-seizure behaviour? Yes ☐ No ☐

If yes, please describe**:**

Click here to enter text.

Action: *If a seizure is suspected, stay with the child. Remain calm, and re-direct the child to a safe place (e.g. a mat on the floor). Follow seizure first aid as appropriate and as described in this plan.*

Typically how many seizures does your child have per day/week/month (as applicable)?

Click here to enter text.

If seizures occur less frequently, please indicate when the last seizure occurred.

Click here to enter text.

In the past, identify the type of seizures your child has experienced:

☐Convulsive seizures*; please describe*:

Click here to enter text.

☐Non-convulsive seizures; *please describe:*

Click here to enter text.

☐Both convulsive and non-convulsive seizures

If your child has a seizure in school, when do you want to be called/notified? For a convulsive seizure, please specify:

Click here to enter text.

For a non-convulsive seizure(s), please specify:

Click here to enter text.

Cluster Seizures

Cluster seizures refer to the "in and out" presentation, where seizures repeat with apparent recovery between the end of one seizure and the beginning of another seizure.

Does your child typically experience cluster seizures? Yes ☐ No ☐

If yes, describe what they generally look like:

Click here to enter text.

Describe how staff are to assess when one seizure has stopped and another one starts?

Click here to enter text.

When is 911 to be phoned in response to clusters? (For example: (number) of seizures with in

minutes ***OR*** if a cluster of seizures lasts for minutes.)

Rescue Medicine	**My child is prescribed a rescue medication: Yes ☐ No ☐** ***If yes,*** complete the following section: ***Note: Rescue medication teaching must be done in collaboration with a regulated health care professional. Instructions for administration will be provided during the training session and should be attached to this plan. In addition, the medication should be documented and stored according to your school board's policy; it is recommended that the medication be stored together with a set of gloves.***

Medication	Dose	Route
☐**Ativan** ☐**Midazolam** ☐**Diazepam(Diastat)** ☐**Other; please specify:** Click here to enter text.	**mg**	☐**Buccal (inside the cheek)** ☐**Rectal** ☐**Other; please specify:** Click here to enter text.
Indications: (Write the order as it is prescribed) Click here to enter text.		
When to call 911: ☐give rescue medication and **call 911** simultaneously ☐if the seizure has not stopped 2 minutes after rescue medication has been given, **call 911** ☐other; please specify Click here to enter text.		

Signs of Seizure Activity	**<u>Convulsive seizures</u> are characterized by stiffening, falling, jerking.** **Signs of Seizure Activity (list is not all inclusive and may vary each time the child has a seizure):** ☐**Sudden cry or moan** ☐**Stiffness (tonic)** ☐**Rhythmic muscle jerks (clonic)** ☐**Fall without warning** ☐**Shallow or temporary stoppage of breathing** ☐**Cyanosis (skin color turns blue)** ☐**Bite tongue or cheek** ☐**Choking or gurgling sounds** ☐**Excessive drooling** ☐**Loss of bladder or bowel control** ☐**Unresponsive to physical stimulation (e.g. the tickle test)** ☐**Other:** Click here to enter text.
Transfer Guidelines	*Note: It is most safe for a child to be on the floor, on their side or abdomen during a seizure.* **If your child is in a wheelchair, or has mobility challenges the staff must consider, please describe guidelines for transfer during a seizure, including when and how:** Click here to enter text. **N/A ☐**

Convulsive Seizures: Emergency And Post Seizure Care	**Time Based Intervention**	**Action: Steps in Order**
	If a seizure lasts less than 5 minutes	**<u>At the onset of the seizure:</u>** 1. Remain calm and stay with the child. 2. Time the seizure. 3. Protect the child from injury: ● lower the child to the floor if they are not already there and position them on their side or abdomen ● remove dangerous objects from surroundings ● loosen clothing around the child's neck ● do not restrain the child ● do not put anything in the child's mouth 4. Provide reassurance. 5. If rescue medication is prescribed, give as directed. 6. Call parents as directed in this plan. *Note: If the child is eating when the seizure starts, do not attempt to remove the food from his/her mouth. Follow the steps listed above. When the seizure stops encourage the child to spit out what is in their mouth.* **<u>Post Seizure Care</u>** **Once the seizure stops, then:** 1. Roll the child onto their side if they are not already there. 2. Talk to and reassure the child and others. Attempt to keep the environment calm and quiet. 3. Re-orientate if needed. ***4.*** Allow the child to rest; do not give food or drink until fully recovered. The child may sleep minutes-hours after a seizure, and may have to go home. 5. Record the seizure: ● describe observations (e.g. movement, face eyes, respiratory effort) and behaviour before, during and after the seizure ● document time of onset and duration of seizure ● identify what activities the child was doing when the seizure occurred, including their location. ● describe interventions taken by staff, including the time and dose of the rescue medication given if applicable.

	Time Based Intervention	Action: Steps in Order
Convulsive Seizures: Emergency And Post Seizure Care	**If the seizure lasts 5 minutes or longer and/or:** • consciousness and/or regular breathing does not return after the seizure has ended • seizures repeat/occur when there is not complete recovery between the end of one seizure and the beginning of another a seizure • if confusion persists for longer than one hour • **as directed by parent, physician, or special patient protocol: please specify:** Click here to enter text.	1. **Call 911* this is an emergency** 2. Contact parents if they have not yet been notified. 3. Remain calm, provide reassurance, and stay with the child until the paramedics arrive. 4. Record the seizure: • describe observations (e.g. movement, face eyes, respiratory effort) and behaviour before, during and after the seizure • document time of onset and duration of seizure • identify what activities the child was doing when the seizure occurred, including their location ***Rescue Medication Reminder*** (if applicable): Administer at minutes and phone 911: ☐simultaneously ☐in two minutes if the seizure has not stopped ☐other, please specify: Click here to enter text.
No		

n-Convulsive Seizures	***<u>Non-convulsive seizures</u> are characterized by staring blankly, confusion, unresponsive, repetitive, purposeless movements. Non-convulsive seizures may spread to other areas of the brain and a convulsive seizure may follow.***	
	Signs of Seizure Activity	**Action: Steps in Order**
	If applicable, describe how your child typically presents with this type of seizure: Click here to enter text.	**<u>At the onset of the seizure:</u>** 1. Stay calm, and let the seizure take its course. 2. Time the seizure. 3. Protect the child from injury • move dangerous objects out of the way • do not restrain the child • gently guide the child away from danger/block hazards • encourage the child to lay in the recovery position 4. If rescue medication is prescribed, give as directed Call parents as directed in this plan.
Non-Convulsive Seizures		**<u>Post Seizure Care</u>** **Once the seizure stops, then:** 1. Talk to and reassure the child and others. 2. Record the seizure • describe observations (e.g. movement, face eyes, respiratory effort) and behaviour before, during and after the seizure. • document time of onset and duration of seizure • identify what activities the child was doing when the seizure occurred, including their location • describe interventions taken by staff, including the time and dose of the rescue medication given, if applicable. **Call 911** at 5 minutes if there are still signs of seizure activity, or as directed by parent, physician, or special patient protocol. *Please specify:* Click here to enter text.

Post Seizure		
	Describe your child's feelings/mood/behaviour after a seizure occurs: Click here to enter text.	

Authorizations & Co	**Parent/Guardian/Student (if appropriate) Authorization** **Re: Consent to Release Information of the Health and/or Emergency Care Plan**

n
se
nt
s

I authorize and hereby consent for school staff to use and/or share information found on this form for purposes related to the education, health, and safety of my child. This may include but is not limited to:

1. Display of my child's photograph in hard copy or electronic format so that staff, volunteers, and school visitors will be aware of his/her medical condition.
2. Place a copy of this plan in appropriate locations in the school including storing an electronic copy in my child's confidential record.
3. Communication with school bus operators, or other school designated person(s) providing transportation.
4. Any other circumstances that may be necessary to protect the health and safety of my child.

_____ _____

Date *Parent/Guardian Signature*

_____ _____

Date *Student (if appropriate)*

Parent/Guardian/Student (if appropriate) Authorization
Re: Consent for Implementation of the Health and/or Emergency Care Plan

I have provided the information above and agree with the identified health care needs, interventions and/or the emergency responses outlined in this plan. I am aware that school staff are not medical professionals and will perform all aspects of the plan to the best of their ability and in good faith.

_____ _____

Date *Parent/Guardian Signature*

_____ _____

Date *Student (if appropriate)*

Note: It is the parent(s)'/guardian(s)' responsibility to notify the principal if there is a need to change the Health and/or Emergency Care Plan throughout the school year. This authorization may be cancelled upon receipt of written notification to the principal.

Authorizations

_____ _____

Date *Regulated Health Care Professional Signature and Designation*

_____

Print Name

_____ _____

Date *Principal*

_____

Print Name

Plan is effective on: (insert date) _____

NOTE: Plans need to be reviewed, updated, and signed annually.