



**School District of West De Pere
SEIZURE ACTION PLAN/AND TREATMENT AUTHORIZATION**

NAME: _____ **D.O.B.:** _____ **GRADE:** _____
Health Condition: Seizure –Emergency Care

<p><u>PROCEDURE :</u></p> <ol style="list-style-type: none">1. Child should never be left alone.2. Loosen all restrictive clothing around neck.3. Observe and record the seizure.4. Administer Diastat if available and trained staff member is present. *seizure last more than 5 minutes or seizure lasts less than 5 minutes and is followed by another seizure.5. Monitor student.6. Comfort and reassure child after the seizure allowing them to rest.	 <p><u>INTERVENTIONS:</u></p> <ul style="list-style-type: none">• Send someone to get another adult.• Contact Parent Immediately.• If unable to reach parent, contact emergency person identified on student information card.• Give Diastat if available.• Turn child on side and keep child safe.• Do not put anything in child's mouth. Do not restrain.• Place soft object under head.• Monitor time of seizure and when it stopped.• Monitor any movement of body parts, breathing problems or cyanosis (appears blue), any incontinence of stool/urine.
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<p>A Seizure is generally considered an Emergency when:</p> <ul style="list-style-type: none">✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes✓ Repeated seizures without regaining consciousness✓ Student has a first time seizure✓ Student is injured or has diabetes✓ Student has breathing difficulties✓ Student has a seizure in water <p>✓ IF DIASTAT WAS GIVEN</p>	 <p>CALL 911 (ambulance)</p> <p>Transport to: _____</p>
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MEDICATIONS/DOSES

Diastat Acudial: give: dose/route/time of day (BRAND AND DOSE): _____

Other Emergency Medication: _____

Vagal Nerve Stimulator: Yes no _____

MONITORING: Stay with the child; alert healthcare professionals and parent. Tell rescue squad Diastat was given. Treat the child even if parents cannot be reached.

Kept in Office Kept in classroom Kept in backpack

CONTACTS: CALL 911

Parent/Guardian: _____ **Cell:** _____ **Home:** _____

Healthcare Provider Signature: _____ **Phone:** _____ **Date:** _____
(Required)

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection or emergency treatment of my child and for the implementation of this plan. RN may consult with Healthcare provider regarding medications, treatments or procedures as needed throughout the school year.

Parent/Guardian Signature: _____ **Phone:** _____ **Date:** _____

School Nurse: _____ **Date:** _____ **Phone: (920) 337-1087 FAX: (920) 337-1091 dev: 5/23/11**