Plan of Care: Seizures

If changes to any part of this plan are required, please complete a new form (including consent and authorization signatures) and share with all involved.

IDENTIFICATION		
Student's name:	School name:	
Date of birth (mm/dd/yyyy):	Health card number:	MedicAlert® number: ☐ N/A
Does the student carry an Emergency Health Services (EHS) Special Patient Protocol card? ☐ Yes ☐ No *If yes*, what is the Special Patient Protocol card number:		
Allergies:	Medical diagnosis(es):	*Place Photo Here*
Medications required during school hours: ☐ N/A 1. 2. 3.	Location where medication is stored at the school (refer to the Regional Centre for Education's policy): 1. 2. 3.	
Additional information (activity restrictions, safety considerations, etc.):		
Bus Driver Name(s) and Bus Number(s)		
Morning bus: ☐ N/A	Afternoon bus: ☐ N/A	
The bus driver(s) and/or school designated person(s) providing transportation have been notified by the school principal (or designate) of student's medical diagnosis. ☐ Yes ☐ N/A		

Emergency Contacts (*Please prioritize 1, 2, 3, in the order the calls are to be placed.*)

If the student has a seizure in school, when do you want to be called or notified?

1. Name: Relationship:	Home phone: Work phone: Cell phone: Email:	Preferred method of communication: ☐ Phone ☐ Other:
2. Name: Relationship:	Home phone: Work phone: Cell phone: Email:	Preferred method of communication: ☐ Phone ☐ Other:
3. Name: Relationship:	Home phone: Work phone: Cell phone: Email:	Preferred method of communication: ☐ Phone ☐ Other:

Designated School Staff with Training (*to be completed by school staff*)

1.	4.
2.	5.
3.	6.

DEFINITIONS

Convulsive seizures are characterized by stiffening, falling, and jerking.

Non-convulsive seizures are characterized by staring blankly, confusion, unresponsiveness, repetitiveness, and purposeless movements. Non-convulsive seizures may spread to other areas of the brain and a *convulsive seizure* may follow.

GENERAL SEIZURE INFORMATION

Does the student have any warning signs/pre-seizure behaviour? ☐ Yes ☐ No

Action: If a seizure is suspected, stay with the student. Remain calm, and re-direct the student 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 the student have per day/week/month (if applicable)?

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

SIGNS OF SEIZURE ACTIVITY

Signs of seizure activity (the following list is not all inclusive and signs may vary each time the student 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)
- ☐ Staring blankly
- ☐ Other:

Post-seizure: Describe the student's typical feelings/mood/behaviour after a seizure occurs:

Cluster seizures are seizures that start and stop, with recovery between the end of one seizure and the beginning of another seizure.

Does the student typically experience cluster seizures? ☐ Yes ☐ No
If yes, describe what they generally look like:

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

When is 911 to be phoned in response to clusters?
(For example, three seizures within a five-minute time frame or if a cluster of seizures lasts for more then 10 minutes.)

(number) of seizures within (number) minutes OR if a cluster of seizures lasts for minutes.

RESCUE MEDICATION

Note: Rescue medication training 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. Rescue medicine should be documented and stored according to your Regional Centre for Education's policy. It is recommended that rescue medication be stored together with a set of gloves.

The student is prescribed a rescue medication: ☐ Yes ☐ No If yes, complete the following section:

Medication	Dose	Route
☐ Ativan ☐ Midazolam ☐ Other; please specify:		☐ Buccal (inside the cheek) ☐ Intra nasal (in the nose) ☐ Other; please specify:

Write the directions as written on the pharmacy issued medication label

TRANSFER GUIDELINES

Note: It is most safe for a student to be on the floor, their side, or their abdomen during a seizure. ☐ N/A

If the student is in a wheelchair during a seizure, you may transfer the student onto the floor in a side lying position if it is safe to do so. If it is not safe to transfer, then the student may remain in the wheelchair as long as they are belted in and head can be supported by a staff member.

SEIZURE FIRST AID

AT THE ONSET OF THE SEIZURE

1. Remain calm, stay with the student, and provide reassurance
2. Time the seizure.
3. Protect the student from injury:
   - If it is safe to do so, lower the student to the floor if they are not already there and position them on their side or abdomen
   - Do not restrain the student
   - Do not put anything in the student's mouth

Note: If the student is eating when the seizure starts, do not attempt to remove food. When the seizure stops, encourage the student, as applicable, to spit out what is in their mouth.

Is rescue medication prescribed?

NO

- ☐ **Call 911 immediately**
- ☐ **Call 911 at ( ) minutes**
- ☐ **Other; please specify:**

IT IS RECOMMNEDED TO CALL 911 AT FIVE MINUTES IF THERE ARE STILL SIGNS OF SEIZURE ACTIVITY.

YES

Give rescue medication (time)
after seizure activity begins and:

- ☐ **Call 911** simultaneously
- ☐ **Call 911** if seizure activity continues for 2 minutes after giving the rescue medication.
- ☐ Other, please specify

Once the seizure stops:

1.Call parents/guardians as directed.

2. Roll the student onto their side (for convulsive seizures if it is safe to do so).

3. Attempt to keep the environment calm and quiet. Allow student to rest; do not give food or drink until fully recovered.

After a seizure, the student may need to sleep for a few minutes to a few hours, and may have to go home.

Phone 911 if these symptoms persist after the seizure ends:

- If consciousness and/or regular breathing does not return
- If there is **not complete recovery** between the end of one seizure and the beginning of another seizure
- If confusion persists for longer than one hour
- As directed by parent, physician, or special patient protocol. Please specify:

Record the seizure:

- description
- duration
- Where did it occur?
- Interventions by staff. If applicable include the dose and time a rescue medication was given.

PARENT/GUARDIAN (STUDENT, IF APPROPRIATE) CONSENT

Release of Plan of Care Information

I agree with the plan of care outlined in this document. 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.

I understand that it is my responsibility to notify my child's principal if there is a need to change or cancel this plan during the school year. If I wish to change or cancel this plan, I will do so in writing.

I authorize school staff to share information from this plan for purposes related to the education, health, and safety of my child. This may include

- displaying my child's picture in hard copy or electronic format so that staff, volunteers, and school visitors will be aware of my child's medical condition
- placing a copy of this plan in appropriate locations in the school and storing an electronic copy in the Nova Scotia Student Information System
- communicating with school bus drivers or other designated persons who may be transporting my child
- any other sharing of information that may be necessary to protect the health and safety of my child

✍ _____ _____

Parent/Guardian Signature mm/dd/yyyy

✍ _____ _____

Student Signature (if appropriate) mm/dd/yyyy

AUTHORIZATIONS

My name below indicates that I have reviewed and am in agreement with the information contained in this Plan of Care and when needed have been in contact with the authorized prescriber and/or other regulated health care provider(s) for clarification and verification as indicated below.

✍ _____ _____

Regulated Health Care Professional Signature mm/dd/yyyy

_____ _____

Print Name Print Designation

As applicable, name of authorized prescriber and/or regulated health care provider and date of contact:

_____

✍ _____ _____

Principal Signature mm/dd/yyyy

_____

Print Name

The signature of the SHP Nurse below indicates involvement in the development of this plan.

✍ _____ _____

School Health Partnership (SHP) Nurse Signature (when applicable) mm/dd/yyyy

_____

Print Name

PLAN OF CARE EFFECTIVE DATE

This plan is effective as of _____ (mm/dd/yyyy). *Note: Plans of care must be reviewed, updated, and signed annually.*