

FLAT ROCK HAWCREEK SCHOOL CORPORATION – SEIZURE HEALTH CARE PLAN

School Year _____

Child's Name _____ Age _____ D.O.B. _____ Grade _____

Allergies _____

Seizure Types _____

Description _____

Treatment Order:

☐ DIASTAT® AcuDial™ (diazepam rectal gel) _____ mg rectally prn for:
seizure > _____ minutes OR for _____ or more seizures in _____ hours

☐ Use VNS (vagal nerve stimulator) magnet _____

☐ Other _____

Following a seizure: (Please check off)

☐ Child should rest in nurse's office

☐ Child may return to class

☐ Parents/Caregiver should be notified immediately

☐ Parents/caregiver should receive a copy of the seizure record sent home with the child

Call 911 if:

☐ Seizure does not stop by itself or with VNS within _____ minutes

☐ Seizure does not stop within _____ minutes of administering DIASTAT® AcuDial™

Physician Information:

Physician/NP/PA Printed Name: _____

Signature _____ Date _____

Address _____

Phone Number _____ Fax _____

Parent Information:

Parent/Guardian #1: _____ Phone: _____

Parent/Guardian #2: _____ Phone: _____

I, _____, parent/guardian of _____

give consent for the above mentioned doctor to release and or disclose medical records and or information relating to the care of the above mentioned student to the school nurse at the respective school located within the Flat Rock Hawcreek School Corporation, Hope, Indiana.

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Step 1. Confirm seizure

Signs and Symptoms

When I am having a seizure, I might display some of the following signs or symptoms:

- ☐ Convulsions Stiffening
- ☐ Unconsciousness Staring
- ☐ Involuntary rhythmic movements
- ☐ Other _____

Step 2. Provide basic first aid

To ensure my safety, here are some steps to follow:



1. Cushion head, remove glasses.



2. Loosen tight clothing.



3. Turn on side and keep airway clear.



4. Note the time a seizure starts and the length of time it lasts.



5. Don't put anything in mouth.



6. Don't hold down.

7. As seizure ends...offer help.

Step 3. Treatment options

If I don't regain consciousness within _____ minutes, please:

- ☐ Call 911

**Once 911 is called, please call my emergency contacts below.

- ☐ If this box is checked advise EMTs that I have a VNS magnet

OR

- ☐ Administer DIASTAT® AcuDial™ (diazepam rectal gel)
 - ☐ For seizures that last more than _____ minutes
 - ☐ OR for _____ or more seizures in _____ hours

- ☐ My DIASTAT® AcuDial™ is kept:

Call 911 if

- ☐ I do not start waking up within _____ minutes after seizure is over (after giving DIASTAT® AcuDial™)
- ☐ Seizure does not stop within _____ minutes of giving DIASTAT® AcuDial™
- ☐

Step 4. Notification

Call the following people if:

- ☐ I go to the Emergency Room
- ☐ You are concerned about my response
- ☐ DIASTAT® AcuDial™ is administered
- ☐ Other _____

Emergency Contacts

Name _____

Phone (____) _____

Name _____

Phone (____) _____