SD 42 PROCEDURE: 9610.2

SEIZURES

Purpose(s)

To provide guidelines for developing an individual school plan that creates and maintains as safe and healthy an environment as is reasonably possible for students with seizures.

Definition

Seizures happen when the brain's electrical pathways are temporarily interrupted. These interruptions can happen frequently, rarely or only in extreme circumstances (stress, etc.). Children can experience many types of seizures.

Process

1. The parent(s)/guardian(s) will inform the Principal of the student's seizure condition and complete the Seizure Action Plan.

2. The parent(s)/guardian(s) must arrange a meeting with the Principal prior to the student's first day in a school or any time there is a change in the student's medical condition. The Principal will inform all relevant staff.

3. A meeting with the student's teacher(s) will be arranged as soon as possible.

4. The public health nurse may be informed of the student's condition.

5. The Seizure Action Plan (attached) will be reviewed by the parent(s)/guardian(s) and school staff involved with the student. The public health nurse may be invited to attend the meeting.

6. Following discussion with a student with a seizure condition and his/her parent(s)/guardian(s), and with permission from them, other students and parents in the class may be given information of the student's condition.

7. All staff will receive education about Seizure conditions. Identified staff will receive training, which will include instruction on the administration of the Seizure Action Plan.

8. It is vital that students with seizures be easily identified. The Seizure Action Plan must be in the Medical Alert Binder. Medical alert information (with an up-to-date photograph of the student) may be posted at various locations such as the student's classroom, medical room and any other room used on a regular basis by the student.

9. The student's emergency medication (if applicable) will be stored in a secure location, and these locations will be made known to all staff.

RECEIVED FOR INFORMATION: September 23, 2015

SEIZURE ACTION PLAN

NOTE: NO MEDICATION WILL BE GIVEN UNTIL THIS FORM IS COMPLETED AND RETURNED TO THE SCHOOL. This form is to be completed by the parent or legal guardian.

NOTE: Complete Anaphylaxis Emergency Procedure Plan for Anaphylaxis; complete Type 1 Diabetes Action Plan for Type 1 Diabetes Management.

A copy of this form must accompany the student to hospital

A. EMERGENCY CONTACT INFORMATION	
Student's Name:	**School:**
Care Card #:	**Birthdate:**
Address:	
Parent/Guardian #1:	
Phone #1:	**Phone #2:**
Parent/Guardian #2:	
Phone #1:	**Phone #2:**
Family Physician:	**Phone:**
Other Physician:	**Phone:**
Medical Condition:	
Any known allergies:	
DO NOT COMPLETE SECTIONS B, C, D and E FOR STUDENTS WHO ARE FOLLOWED BY NURSING SUPPORT SERVICES (NSS) – SEE NSS CARE PLAN	

B. HISTORY OF SEIZURE CONDITION	
Diagnosed with Seizures (year):	Last Seizure:
Frequency:	Duration:
Describe your child's seizures: (type of seizure, symptoms, warning signs, triggers) ☐ Tonic Clonic (Grand Mal) ☐ Absence (Petit Mal) ☐ Partial Seizures ☐ Tonic (Drop Seizure) ☐ Myoclonic	
Special Considerations and Precautions (regarding school activities, sports, trips, physical education etc.):	

C. MEDICATION: IS MEDICATION REQUIRED AT SCHOOL? YES ☐ NO ☐				
	NAME OF MEDICATION:	**DOSAGE:**	**WHERE KEPT?**	**DIRECTIONS FOR USE (per physician and pharmacist's directions):**
1.				
2.				
3.				

D. MEDICAL INTERVENTION	
CONVULSIVE SEIZURES	**NON CONVULSIVE SEIZURES**

STAY WITH THE CHILD
• Protect from injury:
  o Remove any sharp or solid objects from nearby
  o Cushion the child's head
• Loosen anything tight around neck
• Do not restrain the child
• Do not put anything in the child's mouth
• Gently roll child on side
• Stay with the child until they are reoriented
• Record time
• School staff will document seizure on 'Seizure Activity Record' form if required
• **Other interventions required** (e.g. emergency medication):
	STAY WITH THE CHILD
	• Remove any dangerous objects from nearby
	• Do not attempt to move child until reoriented
	• Don't try to stop the child from wandering unless the child is in danger
	• Don't shake the child or shout
	• Record time
	• School staff will document seizure on 'Seizure Activity Record' form if required.
	• **Other interventions required** (eg. emergency medication):

Call parents when:	Call parents when:
Call 911 when:	Call 911 when:

E. AUTHORIZATION

I agree:

- To supply the medication to the school in the original container(s) with the child's name, prescribing physician and pharmacist's directions for use including dosage.
- To keep an adequate supply of current medication at the school.
- To supply my child with a medical alert bracelet, necklace or watch.
- To contact the school and provide revised instructions if changes occur. I am aware I am required to update this information as needed and no less than annually.
- That the Public Health Nurse for the school may be informed of my child's condition and treatment and that the Nurse may contact me if necessary.
- That the staff working with my child may need to know of my child's condition and/or the medication required.
- To the identification of my child as a person with seizures, I understand that this may include the display of pertinent information including a picture of my child in strategic locations within the school. It is understood that the reason for this display is to enable the staff of SD No. 42 and its agents to be able to respond to potential emergencies in a timely fashion. It is clearly understood that student confidentiality will be maintained wherever possible.

Parent/Guardian Signature:	Date Completed:
Principal's Signature:	Date Completed:

Copies: ☐**Parent(s)** ☐**Student File** ☐**Medical Alert Binder** ☐**TTOC File** ☐**School Nurse** ☐**Student Information System Inputted**

June 2015

This Seizure Action Plan has been collaboratively developed by Fraser Public Health, and School District No. 42. The information collected on this form is subject to and protected by the provisions of the Freedom of Information and Protection of Privacy Act.

Seizure Activity Record Form

***Name**:*	***DOB**:*	***Setting:***
Date and time of onset of seizure:		
Duration of seizure:		
Warning signs/aura (cried out, fell down)		
Head (arched, turned to side, grimaced)		
Eyes (rolled, twitched)		
Mouth (drooled, vomited)		
Arms (flexed, extended, jerking)		
Body (limp, stiff, jerking)		
Legs (flexed, extended, kicking)		
Side of body seizure started		
Skin (pale, flushed, blue, cool, warm)		
Incontinent of urine or stool		
Breathing pattern (shallow, noisy, irregular)		
Level of consciousness (responsive, unresponsive)		
Other observations: (feverish, ill)		
Activity/behaviour before seizure (classroom, playing)		
Activity/behaviour after seizure (sleepy, weak, confused, alert)		
Action: (general seizure management, call 911, contact parents, medication given)		
Observed/Recorded by:		