Chester County Technical College High School
2011/2012 Emergency Action Plan for Seizure Disorders

Dear Parents/Guardian, In order to provide your child with the best possible health care please have your physician fill out this questionnaire at your next scheduled appointment. When leaving medication at school, all medications and supplies must in their original container, labeled with your child's name and date of birth. Medications and supplies are returned to the parent at the end of the school year.

STUDENT NAME: ____ **DATE OF BIRTH:** ___________

SEIZURE TYPE:

☐Absence ☐Generalized ☐Status Epilepticus ☐Non-Epileptic ☐Partial ☐ Other: _____________

Date of last seizure: _________ Length of last seizure: _______ Frequency of seizures: _________________________

Please describe what happens to your child during a typical seizure:

LEVEL OF CONSCIOUSNESS

_____Drowsy

_____Confused

_____Unresponsive

_____Unconscious

_____Other________________

OTHER SIGNS

_____Sweating

_____Tongue Biting

_____Dropping of head

_____Repetitive Purposeless Acts

_____Facial twitching

_____Excessive saliva or drooling

_____Speech changes

_____Bladder/bowel incontinence

EYES

_____Open

_____Closed

_____Rolled up

_____Fixed Staring

_____Blinking

EXTREMITIES INVOLVED

_____All Extremities

_____Arms __ right __ left

_____Legs __ right __ left

_____Jerking (intense motor movements)

_____Stiff

_____Twitching (mild motor movements)

  _____Intermittent

  _____Continuous

AFTER SEIZURE

_____Relaxed

_____Drowsy

_____Brief sleep time________

_____Talkative

_____Alert

_____Confused

_____Upset

COLOR

_____Pale

_____Flushed

_____Blue

_____No Change

RESPIRATIONS

_____ Normal

_____Decreased

_____Increased

DAILY MEDICAL MANAGEMENT: Please attach list if addition medications are used

	Name of drug	Dosage	Route	Time
1)	________________________________	____________	_________	________
2)	________________________________	____________	_________	________

OUTSIDE ACTIVITY AND FIELD TRIPS

The following medications must accompany child when participating in outside activity and field trips:

	Name	Dosage	Route	When to Use
1	______________________________	_________	_________	____________________________________
2	______________________________	_________	_________	____________________________________

My child had a vagal nerve stimulator implanted _____**Yes** _____**No**

DISASTER PLANNING: Please consider that in a disaster your child may not have access to medical supplies for up to 72 hours. The health office encourages students with special medical considerations to keep a 72-hour supply of medication and supplies at school for use in the event of a disaster.

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STUDENT NAME: ____ **DATE OF BIRTH:** ___________

In the event of a seizure:

_____Assist the student to a position of safety

_____Time the seizure

_____Remove objects that may cause secondary injury

_____Position to allow secretions to flow out

_____Loosen clothing that may interfere with breathing

_____Do not stimulate by rubbing face or arms

_____**Notify parents/ guardians**

_____Other: ____

If the seizure lasts more than 5 minutes please do the following:

☐Administer medication: ___________________________ _____________ ________________
Name dosage route

☐Other: ____

☐**Activate Emergency Medical Services (911)**

For multiple seizures (#______ within ________minutes) please do the following:

☐Administer medication: ______________________________ ____________ _______________
Name dosage route

☐Other: ____

☐ **Activate Emergency Medical Services (911)**

This information will be shared with emergency services if activated

____ _________________
Physician Date

____ _________________
Parent/Guardian Date