Our Lady of Mt. Carmel School
SEIZURE ACTION PLAN

Student Name: _____ Grade: _____ DOB: _____
Mother's Name: _____ Phone: _____
Cell: _____
Father's Name: _____ Phone: _____
Cell: _____
Guardian Name: _____ Phone: _____
Cell: _____
Emergency Contact: _____ Phone: _____
Cell: _____
Emergency Contact: _____ Phone: _____
Cell: _____
Physician: _____ Phone: _____
Name
_____ Fax: _____
Address
Significant Medical History: (please include allergies & special diet needs) _____
_____

Seizure Type	**Length**	**Frequency**	**Description**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Seizure triggers or warning signs: _____
Does student have any activity restrictions? *Please address playground activity, field trips, P.E., etc:*
_____
Does student need any special activity adaptions/protective equipment (ex. Helmet) at school?
No _____ Yes _____ explain: _____

MEDICATIONS:

Daily Medication	**Dosage and Time of Day Given**	**Common Side Effects and Special Instructions**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Student Name: _____ **Grade:** _____ **DOB:** _____

TREATMENT:

☐ Diastat AcuDial (Diazepam rectal gel)_____mg rectally
Prn for: seizure >___minutes OR for _____(number) or
More seizures in _____hours.

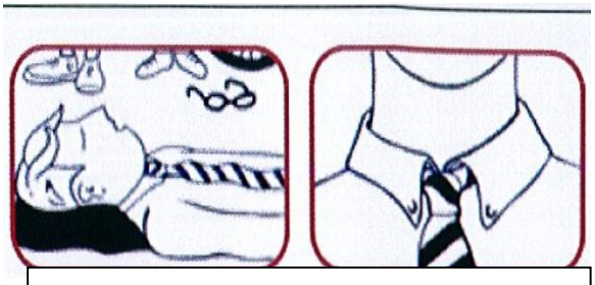
☐ Use VNS (Vagal Nerve Stimulator) magnet (describe
Magnet use):_____

☐ Other: _____

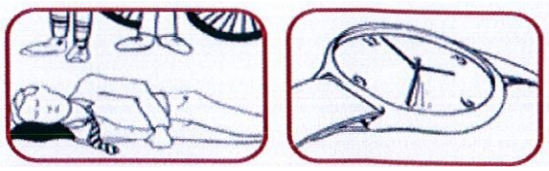
☐ Call 911 if:

- The seizure continues longer than 5 minutes
- There are repeated seizures
- The child is having trouble breathing or has a dusky color
- With correct positioning
- The child has injured himself/herself during the seizure
- Child has diabetes or is pregnant

☐ Following a Seizure (please check all that apply):
___ Child should rest in nurse's office
____ Child may return to class if back to normal
____ Parents/Caregiver should be notified immediately
____ Parents/Caregiver should receive a copy of the seizure record sent home with the child.



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**

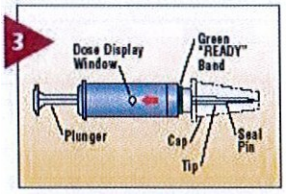
7. As seizure ends….offer help.

Student Name: _____ Grade: _____ DOB: _____

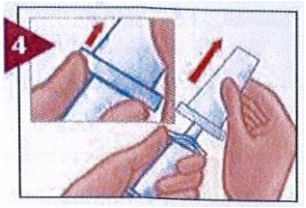
DIASTAT AcuDial (diazepam rectal gel) Administration Instructions

Lay person on side where they cannot fall.

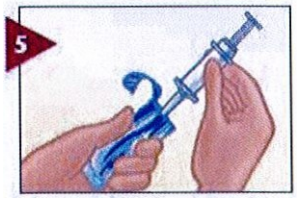
Get medicine.



Get syringe. *Note: Seal/ Pin is attached to the cap.*

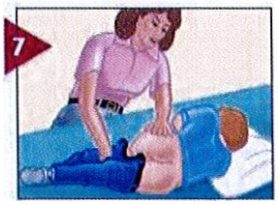


Push up thumb and pull to remove cap from syringe. Be sure Seal Pin is removed with the cap.

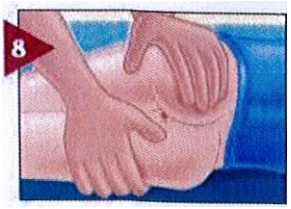


Lubricate rectal tip with lubricating jelly.

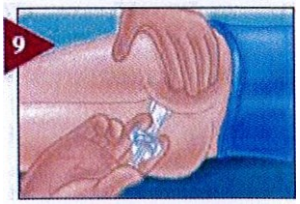
Turn person on side facing you.



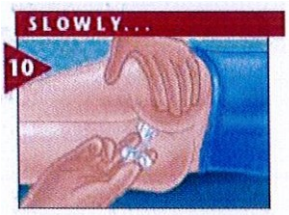
Bend upper leg forward to expose rectum.



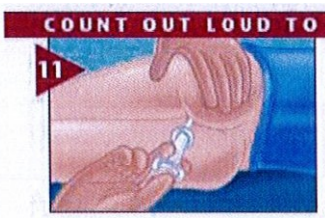
Separate buttocks to expose rectum.



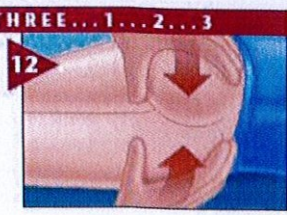
Gently insert syringe tip into rectum.
Note: Rim should be snug against rectal opening.



Slowly count to 3 while gently pushing plunger in until it stops.



Slowly count to 3 before removing syringe from rectum.



Slowly count to 3 while holding buttocks together to prevent leakage.

Keep person on side facing you, note time given and continue to observe.

Disposal Instructions for Diastat Acudial

- Pull on plunger until it is completely removed from the syringe body.
- Point tip over sink or toilet.
- Replace plunger into syringe body, gently pushing plunger until it stops.
- Flush toilet or rinse sink with water until gel is no longer visible.
- Discard all used material in the garbage can.
- Do not reuse.
- Discard in a safe place away from children.

I give my permission for a non-nursing staff member, trained by the school nurse, to administer Diastat or activate the VNS as prescribed by the healthcare provider.

Comments/special instructions: _____

_____

Parent Signature: _____ Date: _____

Physician Signature: _____ Date: _____