Ministry of Education and Child Care

Seizure Action Plan & Medical Alert Information

Student's Name: _____ **Date of Birth:** _____

Instructions: This form is a communication tool for use by parents to share information with the school in order for school staff to provide seizure first aid/care support at school. Please plan to review and update this form yearly or if any changes in condition and/or treatment.

Review Date(s):_____ Expiry Date: June 30, 20____

PART 1: PARENT/GUARDIAN COMPLETES

Name of Student:	Date of Birth:	Care Card Number:	Date Plan Initiated:
School:	School Year: / Grade/Division:	Teacher:	

CONTACT INFORMATION: Please indicate who is to be called first and which number

Parent/Guardian 1: ☐ **Call First**	Name:			
	☐ Cell Number:	☐ Work Number:	☐ Home Number:	☐ Other Number:
Parent/Guardian 2: ☐ **Call First**	Name:			
	☐ Cell Number:	☐ Work Number:	☐ Home Number:	☐ Other Number:
Other/Emergency:	Name:			Relationship:
	Able to advise on seizure care: ☐ Yes ☐ No		Home Number:	Work Number:
	Neurologist:	Phone Number:	Family Physician:	Phone Number:

GENERAL COMMUNICATION:

1. What is the best way for us to communicate with you about your child's seizure(s)?

_____
_____
_____
_____

2. Significant medical history or conditions

_____
_____
_____
_____

3. Have emergency supplies been provided in the event of a natural disaster?
   ☐ YES ☐ NO
   If YES, please explain:

_____
_____
_____
_____

Seizure Action Plan & Medical Alert Information

Student's Name: _____ **Date of Birth:** _____

SEIZURE INFORMATION:

4. When was your child diagnosed with seizures or epilepsy?

_____
_____
_____
_____

5. When was your child's last seizure?

_____
_____
_____
_____

6. When did your child last receive a seizure rescue medication/intervention?

What medication?	What setting?	Who gave the medication?	What was the child's response?

7. Does your child have cluster seizures? If so, please provide description.

_____
_____
_____

8. Has your child ever been hospitalized for continuous / prolonged seizures?
☐ YES ☐ NO If YES, please explain:

_____
_____
_____

Seizure Action Plan & Medical Alert Information

Student's Name: _____ **Date of Birth:** _____

PART 2: PARENT/GUARDIAN AND SCHOOL COMPLETE

SPECIAL CONSIDERATION & PRECAUTIONS

9. Describe any other considerations or precautions related to your child's seizures. Consider the following areas: physical functioning, learning, physical education (gym), behaviour, mood, bus transportation, fieldtrips, and recess/lunch.

_____
_____
_____
_____
_____
_____

10. I confirm I have discussed my child's seizures and plan with school contact.
☐ YES ☐ NO

Name: _____ Relationship: _____

Telephone: _____ Email: _____

Date: _____ Signature: _____

Parent/Guardian Name	Parent/Guardian Signature	Date:

School Based Team Lead or School Administrator	Date:

Ministry of Education and Child Care

Medical Order Form
For Standardized In School Seizure Rescue Interventions

Student's Name: _____ **Date of Birth:** _____

PART 3: MEDICAL ORDERS FOR SEIZURE RESCUE INTERVENTION (LORAZEPAM / MIDAZOLAM / VNS) IN SCHOOL SETTING

SEIZURE MEDICATION AND TREATMENT INFORMATION - Standard Order Form

*Instructions: **Physician to complete**. This information will guide school personnel (non-medical people) in the administration of lorazepam or midazolam or the use of the Vagus Nerve Stimulator (VNS) at school.*

1. Daily anti-seizure scheduled medication(s) needed **at school** (that **cannot** be scheduled before / after school):

Medication	Dosage	Frequency	Time of day (if taken at school)	Comments

2. Calling for emergency help:
   ☒ Call 911: ☐ at start of seizure ☐ after ____ mins of seizing ☐ if seizure has not stopped ____ minutes after the rescue medication/VNS was given ☐ Other (specify): _____
   ☒ Call parent/guardian: ☒ when lorazepam/midazolam given as student must be picked up from school within 30 minutes for ongoing care or 911 will be called ☐ at start of seizure ☐ after ____ mins of seizing ☐ Other (specify): _____
3. Emergency Medication/Intervention in the school setting (tick all that apply):
   ☐ Student does not need/receive any seizure rescue medication in the school setting.
   ☐ Student requires seizure first aid ONLY as per this seizure action plan.
   ☐ Student requires seizure first aid and seizure rescue intervention in the school setting as ordered below.

Rescue Intervention	Dosage	Administration Instructions (timing & method) *(Medication must have expiry date labelled)*
Lorazepam (buccal *ONLY*)	_____ mg = _____ tablet(s)	☐ Single seizures: Administer **lorazepam** if seizure lasts for longer than **5 minutes.** ☐ Cluster seizures: Administer **lorazepam** if seizures occur more than **3 times in 30 minutes.** **NOTE: ONLY one dose** of lorazepam will be administered in school.
Midazolam (intranasal *ONLY*) (volume *must be* rounded up/down to the nearest 0.0 or 0.5 ml)	_____ mg = _____ ml of **5mg/ml concentration ONLY**	☐ Single seizures: Administer **midazolam** if seizure lasts longer than **5 minutes.** ☐ Cluster seizures: Administer **midazolam** if seizures occur more than **3 times in 30 minutes**. **NOTE: ONLY one dose** of midazolam will be administered in school. ☒ A 3 ml luer lock syringe ONLY must be pre-marked with the student's dosage. Marking this is the responsibility of the family/pharmacy/primary care or clinic team.
Vagus Nerve Stimulator (VNS) (this can be used in combination with or without lorazepam or midazolam order above)		☐ **Swipe** once at onset of seizure. If seizure does not stop, swipe once every ____ **seconds** to a maximum of ____ **times**. If seizure has not stopped after _____ **minutes,** ☐ provide rescue medication as per above, and/or ☐ call 911. ☐ If VNS has already been swiped and seizure stopped, but then student seizes again while waiting for parent/delegate/EMS, VNS may: ☐ (1) not be used again or, ☐ (2) be swiped again (as per orders above) _____ **minutes** after last swipe.

I, the undersigned Neurologist/Physician agree that the:

☐ student's seizure care can be safely managed as above in the school setting.
☐ above orders for the school setting are the same that have been prescribed for the home/other community contexts.
☐ family has been trained in the above and is capable of administration in the absence of a health care provider.
☐ family can communicate with the non-medical school staff about the above ordered rescue interventions.

Physician Name: _____ Date: _____

Physician Signature: _____ Clinic Phone Number: _____

Seizure Action Plan & Medical Alert Information

Student's Name: _____ **Date of Birth:** _____

PART 4: SCHOOL STAFF – CARE & PROTOCOL INSERT *(PARENT/GUARDIAN COMPLETES)*

BASIC FIRST AID: Care and Comfort Measures:

AT THE ONSET OF THE SEIZURE

(see insert page for description of student's seizures)

1. **Stay** calm, stay with the student, and provide reassurance
2. **Call** for help from people around you
3. **Time** the seizure
4. Keep student **safe from injury**
   - ✓ Protect head, put something under head, remove glasses, clear area around student of any hard or sharp objects
   - ✓ Do not restrain
   - ✓ If possible, ease student to the floor and position on **side**. If student in wheelchair/stander/walker, student may remain in mobility device, unless their airway is blocked
   - ✓ Do not put anything in student's mouth
5. **Keep** airway open. **Watch** breathing
6. Other steps that need to be taken in school if student has a seizure:
   - ✓ _____
   - ✓ _____
   - ✓ _____

Has parent/guardian provided lorazepam, midazolam and/or VNS for use in the school setting?

SEIZURE RESCUE MEDICATION or INTERVENTION (see page 4)

NO

YES

Standard Orders:

- ☐ Single seizures: give ____ tablet(s) of **lorazepam** bucally if seizure lasts **longer than 5 minutes**.
- ☐ Cluster seizures: give ____ tablet(s) of **lorazepam** bucally if student has **more than 3 seizures in 30 minutes**.
- ☑ ONLY one dose of medication will be administered at school.

- ☐ Single seizures: give **midazolam** intranasally (draw up medication to line marked on syringe) if seizure lasts **longer than 5 minutes**.
- ☐ Cluster seizures: give **midazolam** intranasally (draw up medication to line marked on syringe) if student has **more than 3 seizures in 30 minutes**.
- ☑ ONLY one dose of medication will be administered at school.

Pediatric Neurologist Exception **Only**

- ☐ Single seizures: give ____ tablet(s) of **lorazepam** bucally if seizure lasts **longer than _____ minutes**.
- ☐ Cluster seizures: give ____ tablet(s) of **lorazepam** bucally if student has **more than_____ seizures in_____ minutes**.
- ☑ ONLY one dose of medication will be administered at school.

☐ Intranasal midazolam	☐ Buccal midazolam
☐ Single seizures: give **midazolam** intranasally (draw up medication to line marked on syringe) if seizure lasts **longer than _____ minutes**. ☐ Cluster seizures: give **midazolam** intranasally (draw up medication to line marked on syringe) if student has **more than _____ seizures in _____ minutes**. ☑ ONLY one dose of medication will be administered at school.	☐ Single seizures: give **midazolam** bucally (draw up medication to line marked on syringe) if seizure lasts **longer than _____ minutes** ☐ Cluster seizures: give **midazolam** bucally (draw up medication to line marked on syringe) if student has **more than _____ seizures in _____ minutes**. ☑ ONLY one dose of medication will be administered at school.

Seizure Action Plan & Medical Alert Information

Student's Name: _____ **Date of Birth:** _____

		☐ **VNS**: Swipe once at onset of seizure. If seizure does not stop, swipe once **every ____ seconds** to a **maximum of ____ times**. If seizure has **not stopped after _____ minutes**, ☐ provide rescue medication as per above, and/or ☐ call 911. ☐ If VNS has already been swiped and seizure stopped, but then student seizes again while waiting for parent/delegate/EMS, VNS may: ☐ (1) not be used again or, ☐ (2) be swiped again (as per the orders above) ____ minutes after last swipe.
CALL 911	☐ Call 911 as soon as seizure starts ☐ Call 911 if seizure has not stopped after _____ minutes ☐ Other; please specify: _____	☐ Call 911 as soon as seizure starts ☐ Call 911 if seizure has not stopped after _____ minutes ☐ Call 911 if seizure has not stopped _____ minutes after giving the rescue intervention ☐ Other; please specify: _____
CALL Family	☐ Call family immediately at onset of seizure ☑ **Call family once seizure rescue medication given as family will need to pick up student from school within 30 minutes. If family does not arrive in time, call 911.** ☐ Other; please specify: _____	
	NOTE: Always call 911 if: ✓ student does not completely recover or return to their usual self after the seizure event ✓ student is injured ✓ student has diabetes ✓ student has breathing difficulties after the seizure ✓ seizure occurs in water ✓ first time seizure ✓ you do not feel able to care for the student safely	
ONCE SEIZURE STOPS	1. Stay with student until fully conscious. 2. Reassure. Reorient to surroundings. 3. Allow student to rest. Keep environment calm and quiet. 4. Do not give student any food or drink until student is fully recovered. 5. Call parent/guardian if not already done so 6. Other student specific needs: (e.g. will student need to leave the classroom? Does student need to lie down, etc?)_____	
ONCE 911 ARRIVES	☑ Share this seizure action plan with EMS ☑ Give EMS a report of what happened and the care the student received	
RECORD	☐ Description of seizure ☐ How long the seizure lasted ☐ Where did the seizure occur? ☐ What time did the seizure start? ☐ All care provided, including the time the rescue medication/intervention was provided ☑ Return completed record to school administration	
REVIEW	☐ School and family to review student's seizure action plan each time it is used to verify procedures and make any necessary changes	

Seizure Action Plan & Medical Alert Information

Student's Name: _____ **Date of Birth:** _____

Appendix A: Seizure Type(s) and Description(s)

Seizure Type	Are there any warnings and/or behaviour changes before the seizure occurs?	How do other illnesses and/or any other triggers affect your child's seizure control?	How long does the seizure usually last?	What time of day does the seizure usually occur?	How often do seizures usually occur?	Describe what the seizures look like	Describe how your child behaves after the seizure.	Will the student receive a seizure rescue intervention (lorazepam, midazolam, and/or VNS) for this seizure? (State Yes or No and what type of rescue intervention)

BRITISH COLUMBIA | Ministry of Education and Child Care

Medical Exception Order Form
For Non-Standard In-School Rescue Interventions

To be completed by Pediatric Neurologist only

Student's Name: _____ **Date of Birth:** _____

PART 3: MEDICAL ORDERS FOR SEIZURE RESCUE INTERVENTION (LORAZEPAM / MIDAZOLAM / VNS) IN SCHOOL SETTING

SEIZURE MEDICATION AND TREATMENT INFORMATION – Medical Exception Form[1]

Instructions: Pediatric Neurologist to complete only if student cannot be safely supported on the standard order form. *This information will guide school personnel (non-medical people) in the administration of lorazepam or midazolam or the use of the Vagus Nerve Stimulator (VNS) at school.*

1. Daily anti-seizure scheduled medication(s) needed **at school** (that **cannot** be scheduled before / after school):

Medication	Dosage	Frequency	Time of day (if taken at school)	Comments

2. Calling for emergency help:

☒ Call 911: ☐ at start of seizure ☐ after ____ mins of seizing ☐ if seizure has not stopped ____ minutes after the rescue medication/VNS was given ☐ Other (specify): _____

☒ Call parent/guardian: ☒ when lorazepam/midazolam given as student must be picked up from school within 30 minutes for ongoing care or 911 will be called ☐ at start of seizure ☐ after ____ mins of seizing ☐ Other (specify): _____

3. Emergency Medication/Intervention in the school setting (tick all that apply):

☐ Student does not need/receive any seizure rescue medication in the school setting.
☐ Student requires seizure first aid ONLY as per this seizure action plan.
☐ Student requires seizure first aid and seizure rescue intervention in the school setting as ordered below.

Rescue Intervention	Dosage	Administration Instructions (timing & method) *(Medication must have expiry date labelled)*
Lorazepam (buccal *ONLY*)	_____ mg = _____ tablet(s)	☐ Single seizures: Administer medication if seizure continues more than ___ **minutes.** (*Typically, more than 5 minutes)* ☐ Cluster seizures: Administer medication when seizures occur more than ___ **times in _____minutes**. *(Typically, more than 3 times in 30 minutes)* **NOTE: ONLY one dose** of medication will be administered in school.
Midazolam (Intranasal *ONLY*. If buccal ordered, clear medical rationale required) (volume *must be* rounded up/down to the nearest 0.0 or 0.5 ml)	_____ mg = _____ ml of **5mg/ml** **concentration** **ONLY**	☐ Single seizures: Administer medication if seizure continues more than ___ **minutes.** (*Typically, more than 5 minutes)* ☐ Cluster seizures: Administer medication when seizures occur more than ___ **times in** ___ **minutes**. *(Typically, more than 3 times in 30 minutes)* ☐ Buccal use only (rationale)[1]: _____ **NOTE: ONLY one dose** of medication will be administered in school. ☒ A 3 ml luer lock syringe ONLY must be pre-marked with the student's dosage. Marking this is the responsibility of the family/pharmacy/primary care or clinic team).
Vagus Nerve Stimulator (VNS) (this can be used in combination with or without lorazepam or midazolam order above)		☐ Swipe once at onset of seizure. If seizure does not stop, swipe once every ____ **seconds** to a maximum of ____ **times**. If seizure has not stopped after _____ **minutes** ☐ provide rescue medication as per above, and/or ☐ call 911. ☐ If VNS has already been swiped and seizure stopped but then student seizes again while waiting for parent/delegate/EMS, VNS may: ☐ (1) not be used again or, ☐ (2) be swiped again (as per the orders above) ____ **minutes** after last swipe.

I the undersigned Physician agree that the:

☐ student's seizure care can be safely managed as above in the school setting.
☐ above orders for the school setting are the same that have been prescribed for the home/other community contexts.
☐ family has been trained in the above and is capable of administration in the absence of a health care provider.
☐ family can communicate with the non-medical school staff about the above ordered rescue interventions in the school setting.

Pediatric Neurologist Name: _____ Date: _____

Pediatric Neurologist Signature: _____ Clinic Phone Number: _____

[1] This form is for a student requiring a medical exception ***only***. Please provide specific medical rationale need for buccal order.

Seizure Log

Date:		Time started:
Describe what the seizure looked like (include any changes in student's muscle tone, arm/body movements, colour, breathing pattern, loss of bowel/bladder control):		
How long did the seizure last?		Where did seizure occur (location)?
Care/treatment provided: (if rescue medication given, record name of individual that did the double-check)		
Time parent called:		Time 911 called:
Did student return to usual self after the seizure? ☐Y ☐ N	Comments:	
Recorder's Name:		Initials:

Date:		Time started:
Describe what the seizure looked like (include any changes in student's muscle tone, arm/body movements, colour, breathing pattern, loss of bowel/bladder control):		
How long did the seizure last?		Where did seizure occur (location)?
Care/treatment provided: (if rescue medication given, record name of individual that did the double-check)		
Time parent called:		Time 911 called:
Did student return to usual self after the seizure? ☐Y ☐ N	Comments:	
Recorder's Name:		Initials:

Date:		Time started:
Describe what the seizure looked like (include any changes in student's muscle tone, arm/body movements, colour, breathing pattern, loss of bowel/bladder control):		
How long did the seizure last?		Where did seizure occur (location)?
Care/treatment provided: (if rescue medication given, record name of individual that did the double-check)		
Time parent called:		Time 911 called:
Did student return to usual self after the seizure? ☐Y ☐ N	Comments:	
Recorder's Name:		Initials: