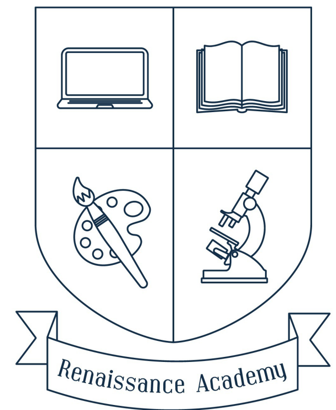
Student Name: ______________________________



Student's photo

Renaissance Academy SEIZURE Medical Action Plan (MAP)

Date of Birth

Age **Grade** **School Year**

Page one of this MAP is to be completed, signed and dated by a parent/guardian.
Page two of this MAP is to be completed, signed and dated by the treating physician or licensed prescriber.
Without signatures this MAP is not valid.
The parent/guardian is responsible for supplying all medications and any other needed equipment/supplies to Renaissance Academy (RA).

CONTACT INFORMATION

		Call First	Try Second
Parent/ Guardian:	Name:	______________	______________
	Relationship:	______________	______________
Phone:	Home:	______________	______________
	Cell:	______________	______________
	Work:	______________	______________

Call Third (If a parent/guardian cannot be reached)

Name: ______________________________ Relationship: ______________

Address: ______________________________ Phone: ______________

SEIZURE HISTORY

Seizure Type (please check all that apply)

Generalized: **Tonic Clonic** (grand mal) **Atonic** (drop attacks) **Myoclonic** **Absence** (petit mal)

Partial: **Simple** **Complex** (psychomotor/temporal lobe)

Other or Description of seizure ______________________________

How long does a typical seizure last__________**How often do seizures occur** ______________

Warning signs (aura) or triggers if any, please explain ______________________________

Age when seizures were diagnosed__________**Date of last exam for this condition** ______________

Student on ketogenic diet YES NO **Past history of surgery for seizures YES NO**

Student's reaction to seizure ______________________________

Does student need to leave the classroom after a seizure? YES NO

If yes, describe process for returning to classroom ______________________________

Notify parent immediately for all seizure activity YES NO

Other instructions ______________________________

Any special considerations or safety precautions: ______________________________

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having seizures to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) I give permission for trained staff to administer any medication ordered for seizure activity and to contact the ordering physician/licensed prescriber for clarification of this plan if needed.

Date____________________ Parent/Guardian ______________________________

Signature

Action if student has a seizure

- **Stay calm & track time**
- **Keep child safe**
- **Do not restrain**
- **Do not put anything in mouth**
- **Stay with child until fully awake**
- **Record seizure in a log**

In addition for tonic-clonic (grand mal) seizure

- **Keep airway open/watch breathing**
- **Protect head**
- **Turn child on side, if able to safely**
- **Follow medical orders (last box below)**
- **Follow directions of parent (page one of MAP)**

General Signs of a Seizure EMERGENCY

- **Convulsion (tonic-clonic/grand mal) longer than 5 minutes** or per 911 instructions below in Order
- **Student has repeated seizures without regaining consciousness**
- **Student is injured, has diabetes, or is pregnant**
- **Student has breathing difficulties, or normal breathing does not resume**
- **Student has a seizure in water**
- **Parents request emergency evaluation**

Action

CALL 911

- **Stay with the student until help arrives**
- **Call parent/guardian**
- **CPR if needed**

Physician/Licensed Prescriber Order & Agreement with Protocol (as outlined in this 2 page plan)

Administer Diastat® rectal gel for seizure lasting longer than_____minutes. Dose__________

Other instructions for Diastat®____

No Diastat® ordered

D es student have a Vagal Nerve Stimulator YES NO (if YES, please describe magnet use)

____

Call 911 if: (please check and complete all that apply)

Seizure does not stop by itself within______minutes

Anytime Diastat is given

Only if seizure does not stop within______minutes after giving Diastat

Other directions or medications:

____

____

Physician/Licensed Prescriber's Name____

Phone number__________________________ FAX number_______________________________

Signature____ Date___________________