OLDHAM COUNTY BOARD OF EDUCATION
ADMINISTRATIVE REGULATION – 9009.05-F

SEIZURE ACTION PLAN

Student Name: ______________________________ DOB: _____________ School: ________________ School Year: __________________

Diastat Expiration Date: ___________

Type of Seizure:

☐ Tonic-clonic (Grand Mal)
☐ Absence (Petit Mal)
☐ Simple Partial
☐ Complex Partial
☐ Other ______________________________________

Does student take daily seizure medication? ☐ Yes ☐ No

Please list: ____________________________________

Does student have a Vagus Nerve Stimulator? ☐ **Yes*** ☐ **No**

*If yes, describe magnet use: ___________________________

____

VNS magnet should be kept with student at all times

DOES STUDENT HAVE A DIASTAT PRESCRIPTION?

☐ **Yes*** ☐ **No**

***If yes, this form requires physician signature and physician must complete orders below. Diastat will be kept in a secured area in the school office/health room or in the classroom with a trained adult.**

If student has DIASTAT, please specify: (physician to complete)

Dose: _______ MG PER RECTUM AND ADMINISTER AT:

☐ **Onset of seizure**

☐ **______ minutes after onset of seizure**

☐ **Other: ________________________________**

EMERGENCY PLAN OF ACTION

1. Student will be eased to the floor unless harnessed securely in a wheelchair and breathing is not restricted
2. **Time the seizure.** Observe and document seizure characteristics. Use vagus nerve stimulator(VNS) and/or rectal Diastat as ordered.
3. The head and body will be protected to prevent injury. Hazards will be removed from the area.
4. Student **will not** be restrained. Objects **will not** be placed in the mouth.
5. Respiratory changes such as skin color, increase/decrease in respiratory rate and noisy or congested breathing will be monitored. **Call 911 for respiratory distress.**
6. Notify school personnel trained in CPR to respond.
7. If seizure subsides or if Diastat needs to be administered, student will be **placed on their side in the recovery position** to promote airway and prevent aspiration. Mouth will be cleaned off, monitor airway.
8. Parent/guardian will be notified and student will be allowed to rest in a quiet, supervised area until parent arrives. After occurrence of Grand Mal seizure student must be taken home to rest/sleep.
9. **If Diastat is administered, call 911.** EMS will arrive to assess student. Should the parent decline transport, parent/guardian will assume responsibility and student must be taken home.
10. If student is transported by ambulance, OCBE staff must accompany student to hospital unless parent/guardian is present.
11. Document all seizure activity on OCBE seizure monitoring form. Place copy in student record. Copy to Health Services Dept.

Call 911 if:

- **Seizure activity lasts longer than five minutes**
- **Diastat is administered**
- **Respiratory distress is noted**
- **Another seizure starts right after the first**
- **First time seizure, no known history**

Reviewed by OCBE Health Services RN: ________________________ Date: _________

SEIZURE ACTION PLAN

Student Name: ______________________ DOB: ____________ School: ____________________

Please specify likely characteristics						**Comments/Other**
Duration/Frequency	Specify seconds, minutes, etc. **Date of last seizure**: ____________					
Aura	Is there an Aura / trigger? ☐Yes ☐ No Conditions or behaviors that usually precede the seizures:					
Extremities	(circle one)	Limp	Flexed	Extended	Jerking	
	Right/left arm					
	Right/left leg					
Eyes	Rolled Back			☐ Yes	☐ No	
	Twitching back and forth			☐ Yes	☐ No	
	Looking to right/left (circle one)			☐ Yes	☐ No	
	Staring			☐ Yes	☐ No	
Mouth	Drawn to right / left (circle one)			☐Yes	☐ No	
	Bites tongue / cheek			☐ Yes	☐ No	
	Teeth Clenched			☐ Yes	☐ No	
Breathing	Noisy / Loud Breathing			☐ Yes	☐ No	
	Shallow Breathing			☐ Yes	☐ No	

TRANSPORTATION DIRECTIVES:

In the event of a seizure during transport, student will remain in seat; breathing and airway status will be monitored by bus staff. **If respiratory distress is noted, or seizure does not subside, 911 will be called.**

IS DIASTAT TO BE ADMINISTERED ON THE BUS ROUTE TO AND FROM SCHOOL? ☐ **Yes*** ☐ **No**

***If** Diastat is prescribed by the physician to be administered during bus transportation to/from school, two trained staff members are required and available only on a 'specially equipped' bus.

IS DIASTAT TO BE ADMINISTERED DURING BUS TRANSPORTATION ON FIELD TRIP EVENTS? ☐ **Yes*** ☐**No**

***For regular education students with a prescribed Diastat: transportation will be provided on 'specially equipped' bus for field trip events unless parent and physician sign the waiver of special transportation on page 3 of this Seizure Action Plan.**

SEIZURE ACTION PLAN

Student Name: ____ DOB: ________________ School: ___________________________

Parent Liability Waiver and Release of Information

I understand that employees of the Oldham County Board of Education to whom health services are delegated may not be licensed healthcare professionals. In the case of an emergency that requires immediate intervention at school or at a school event, employees who have been delegated health services will undertake to do their best to comply with the recommended protocols developed by the student's physician, in accordance with training conducted by a Registered Nurse. I hereby consent to the interventions of the employee in accordance with the instructions above/attached. Additionally, in accordance with KRS 156.502 and 158.383(4), I agree to hold staff members harmless for any injuries resulting from the emergency care, medication administration, or reaction to any medication administration unless the injury was caused by the Board of Education employee's negligence.

I further hereby give my consent for medical records and reports to be shared with the Oldham County Board of Education and for my child's physician, referenced above, to discuss my child's medical condition with designated District personnel to assist them in planning for my child's care while at school or at school events.

Parent/Guardian Signature: ____ Date: ____________ Phone: ____________________________________

Physician Signature: ____ Date: ____________ Phone:________________ Fax: _______________

Physician Printed Name: ____ Address: ____

Waiver of Specially-Equipped Transportation and Release of Liability

I hereby request waiver of special transportation for field trips during the current school year. I understand that my child is entitled to special transportation due to my child's medical condition and that special transportation has been offered by the district at no additional cost to me.

I understand that declining special transportation will result in my child being transported by regular school bus unless the students are traveling by charter bus. The space limitations and configuration of bus seats on a regular school bus pose additional safety risks to my child in the event that Diastat must be administered on the bus. I have evaluated the risks to my child and determined that it is in my child's best interest to be transported by regular bus.

To the extent allowable by law I, for myself, my spouse, my child and our heirs, hereby indemnify and hold harmless my child's school and the Oldham County Board of Education, their members, officers, employees, agents, insurers, successors and assigns from any liability, damages, or injury sustained by my child as a result of the administration of Diastat on a regular school bus while traveling to and from school field trips.

Parent Signature____ Date______________________

I have reviewed the child's medical condition and the risks associated with traveling on a regular school bus and I agree with the parent's request to waive specially-equipped transportation during school field trips.

Physician Signature____ Date______________________

Adopted: June 16, 2010
Revised: May 11, 2013