BRITISH COLUMBIA
Supported by the Province of British Columbia

Seizure Action Plan & Medical Alert Information Care and Protocol

Student's Name _____ Date of Birth _____

This form is a communication tool for use by parents/guardians and the student's most responsible practitioner (MRP) to document and share information with the school in order for school staff to provide seizure care at school. Please review and update this form yearly or sooner if the student has a seizure at school or if there have been any changes in the student's condition and/or treatment.

Instructions for completion of this form:

Parent/guardian to complete all orange sections	**MRP to complete all green sections**	**School to complete all blue sections**

SAP Start Date: _____ SAP Expiry Date: June 30th, 20 ___ *SAP Review Date(s):* _____

NOTE: If the SAP start date is after May 1st, the SAP may be set to expire on June 30th of the following year

PART 1: PARENT/GUARDIAN to fill in this information

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 at 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:	
	☐ Cell Number:	☐ Work Number:	☐ Home Number:	☐ Other Number:
MRP/Neurologist	MRP (name):		Phone Number:	

SEIZURE INFORMATION:

Describe what your child's seizures (single seizures or cluster seizures) look like so the non-medical school staff can recognize them.	
Describe how long your child's seizures normally last.	
Describe any auras (warning signs) that your child is going to have a seizure.	
Describe any triggers that may make a seizure more likely (e.g., illness, lack of sleep).	
Describe how your child usually behaves after a seizure.	
When was the last time your child had a seizure rescue medication?	

PART 2A: PARENT/GUARDIAN and SCHOOL to fill in this information

Signature(s) for After the Parent/Guardian Information Sharing Session with the School-Based Team

By signing below, I/we _____ confirm that I/we have reviewed the information in
Parent/guardian name(s)
this Seizure Action Plan and Medical Alert Information form with my child's school-based team on _____.
Date

Parent/Guardian Name	Parent/Guardian Signature	Date:
Parent/Guardian Name	Parent/Guardian Signature	Date:

PART 2B – SCHOOL to fill in this information (School Based Team Information)

School Based Team Lead or School Administrator: _____

Non-medical school staff who attended the parent information session and NSS Seizure Rescue Intervention Training (if applicable).

Non-Medical School Staff Name	Date of attendance at parent/guardian information session with school-based team	Date of attendance at NSS Seizure Rescue Intervention Training (If applicable)

PART 3: MRP to fill in this information

If applicable, list any daily anti-seizure scheduled medication(s) needed **at school** (that **cannot** be scheduled before/after school):

Medication	Dosage	Frequency	Time of day to be taken at school	Comments

I, the undersigned MRP agree that the: (MRP to tick all and sign)

- ☐ student's seizure care can be safely managed in the school setting as per the care and protocol below.
- ☐ care and protocol orders for the school setting are the same that have been prescribed for the home/other community contexts.
- ☐ parent/guardian has been trained in the ordered seizure rescue intervention(s) (if applicable) and is capable of administration in the absence of a health care provider.
- ☐ parent/guardian can communicate with the non-medical school staff about the care and protocol steps below.

I, the undersigned MRP understand that: (MRP to tick only if applicable)

- ☐ the seizure rescue intervention orders I ordered below are different than the BCCH standard orders for seizure rescue.

Prescriber Name: _____ BC College # or BCCNM Registration # _____

Prescriber Signature: _____ Clinic Phone Number: _____ Date: _____

PART 4: PROTOCOL FOR SCHOOL STAFF TO FOLLOW – PARENT/GUARDIAN AND MRP to fill in this information

If the student has a seizure at school, follow the steps below. Note that not all steps will be applicable for all students.

Step	Steps to be Followed by School Staff During a Seizure	*Who Fills in Each Step*
STEP 1	At the start of the seizure: a) **Stay** calm, stay with the student, and provide reassurance. b) **Call** for help from people around you. c) **Time** the seizure. d) Keep student **safe from injury.** • Protect head, put something under head, remove glasses, clear area around student of hard or sharp objects. • Do not restrain. • If possible, ease student to the floor and position on **side**. If the student is in wheelchair/stander/walker, they may remain in their mobility device, unless their airway is blocked. • Do not put anything in student's mouth. e) **Keep** airway open. **Watch** breathing. f) Other steps that need to be taken in school if student has a seizure: • _____ • _____	***Parent/ guardian** to fill in this information*
STEP 2	If student has a seizure at school, the student: (tick one) ☐ <u>does not</u> require any seizure rescue intervention (beyond first aid), **GO TO STEP 4** on the following page. ☐ <u>requires</u> a seizure first aid and seizure rescue intervention(s), **GO TO STEP 3** below.	***MRP** to fill in this information* ***MRP** must also complete and sign PART 3 above* ***MRP** please round order for midazolam to the nearest 0.0 or 0.5 mL*
STEP 3	If the student has a seizure at school: ☐ **Swipe** the VNS once at onset of seizure. If seizure does not stop, s**wipe once every __ seconds** to a maximum of ____ **times**. If seizure has **not** stopped after ___ **minutes,** ☐ **provide rescue medication** as per below ☐ call 911 ☐ If the VNS has already been swiped and seizure stopped, but the student seizes again while waiting for parent/ambulance, VNS: ☐ may not be used again **<u>OR</u>** ☐ may be swiped again (as per above) ___ minutes after the last swipe.	
	☐ If student has a single seizure that lasts **longer than ____ minute(s)** **<u>OR</u>** ☐ If student has **more than ____ seizures in ___ minutes (cluster seizures)**	**Give ____ mg** of **lorazepam buccal** **(*MRP note: BCCH standard is for seizures longer than 5 minutes and/or more than 3 seizures in 30 minutes)* **Give the single pharmacy labelled dose of lorazepam** as provided by parent/guardian**.** If student has already had lorazepam at school, do not give another dose, call 911.
	☐ If student has a single seizure that lasts **longer than ____ minute(s)** **<u>OR</u>** ☐ If student has **more than ____ seizures in ___ minutes (cluster seizures)**	**Give ____ mg** of **midazolam** ☐ **intranasal** **<u>OR</u>** ☐ **buccal** **(*MRP note: BCCH standard is for seizures longer than 5 minutes and/or more than 3 seizures in 30 minutes)* **Draw up midazolam to the line marked on the syringe** as you were shown by parent/guardian and **give** to student**.** If student has already had midazolam at school, do not give another dose, call 911.

STEP 4	If the student has a seizure at school, **call 911** (tick at least one): ☐ as soon as seizure starts. ☐ if seizure has not stopped after _____ minutes ☐ if seizure has not stopped _____ minutes after rescue intervention was given ☐ Other: _____ ☑ if the student does not completely recover or return to their usual self after the seizure event. ☑ If the student is injured during the seizure. ☑ if the student has diabetes. ☑ if the student has breathing difficulties or looks grey or blue (cyanotic) after the seizure. ☑ if the student has breathing difficulties or looks grey or blue (cyanotic) after the seizure rescue intervention. ☑ if the seizure occurs in water. ☑ if it is the students first time having a seizure. ☑ as soon as the rescue medication is given if this is the first time the student is getting the rescue medication.	***MRP** to fill in this information*
STEP 5	*If the student has a seizure at school, call parent/guardian: (tick one)* ☐ at onset of seizure. ☐ If seizure has not stopped after _____ minutes ☑ If seizure rescue medication is given as parent/guardian will need to pick up student from school within 30 minutes. If parent/guardian does not arrive in 30 minutes, call 911. ☑ Other; please specify: _____	***Parent/ guardian** to fill in this information*
STEP 6	*Once the student's seizure stops:* a) Stay with the student until they are fully awake. b) Reassure the student. c) Reorient student to their surroundings. d) Allow the student to rest. Keep the environment calm and quiet. Do not give the student any food or drink until they are fully recovered. e) Call parent/guardian if you have not already called them. f) Other student specific needs: (e.g., Student will need to leave the classroom. Student will need to lie down.) • _____ • _____	***Parent/ guardian** to fill in this information*
STEP 7	a) Share this seizure action plan with the Emergency Medical Services (i.e., Paramedics) when they arrive. b) Give Emergency Medical Services Paramedics a report of what happened and the care the student received.	
STEP 8	Record the seizure information on the Seizure Log located on the last page of this Seizure Action Plan, and return the completed form to the school administration.	
STEP 9	School and parent/guardian and/or MRP to review the SAP and make changes if needed. Parents/guardians may make changes in the orange sections, the school may make changes to the blue sections, the MRP may make changes in the green sections. The family will share with the school/school staff any changes made to the plan, and the school will submit a new Request for NSS Training form if the MRP has ordered (1) a change the type of rescue intervention/medication (e.g. midazolam to lorazepam or the addition of a VNS) or (2) a change in route of midazolam administration (i.e. buccal to intranasal, or intranasal to buccal).	

Seizure Action Plan & Medical Alert Information
Seizure Log
Student's Name _____ Date of Birth _____

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:
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Recorder's Name:	Initials: