

**Tonic-Clonic Seizure  
Emergency Action Plan**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

<p>Tonic-Clonic (convulsive) seizures are characterized by some combination of the following: sudden cry, fall, and rigidity, followed by muscle jerks, froth/saliva on the lips, shallow breathing or temporarily suspended breathing, bluish skin, possible loss of bladder or bowel control. The seizure usually last less than 3 minutes. The person may be incontinent of urine and/or feces. Normal breathing will start again. There may be confusion and/or fatigue, followed by return to full consciousness. In some rare cases the seizure may go longer than 5 minutes. When that occurs, call 911, and additional medication may be required.</p>	
<p><b>If you see any of these signs:</b></p> <p>Student's aura _____ _____ _____</p> <p>Student's general pattern of seizure. _____ _____ _____</p>	<p><b>Do this:</b></p> <ol style="list-style-type: none"> <li>1. Stay calm</li> <li>2. Stay with student at all times</li> <li>3. Send note or intercom office for nurse</li> <li>4. Note the time</li> <li>5. Do not restrain the student (a seizure can't be stopped once started without medication. Most will be self-limiting.)</li> <li>6. If student is standing or seated, assist them to the floor.</li> <li>7. Clear the area of hard, sharp, or dangerous objects.</li> <li>8. Do not force anything into mouth. The tongue will not be swallowed.</li> <li>9. If possible, turn student onto side with mouth down.</li> <li>10. Loosen necktie or tight clothing at the neck.</li> <li>11. Monitor breathing and pulse. Breathing may become very shallow. CPR is rarely needed.</li> </ol>
<p>If student goes from one seizure into another without gaining consciousness or a seizure lasts for more than 5 minutes.</p>	<p><b>Special Orders:</b></p> <ol style="list-style-type: none"> <li>1. Note the time</li> <li>2. Call 911</li> <li>3. Administer medication, if ordered.</li> </ol>

Additional child-specific instructions (may or may not be filled out)

Nurse will follow protocol for Tonic-Clonic (convulsive) seizures as established by the student's physician or as found in the district's health service handbook.

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

## Seizure Health History

Student's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

**The following information is helpful to your child's school nurse and school staff in determining any special needs for your child. Please answer the questions to the best of your ability. If you desire a conference with the school nurse, please call for an appointment.**

Nurse's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

1. How long has your child had seizures? \_\_\_\_\_
2. What type of seizure does your child have? \_\_\_\_\_
3. What may trigger the seizure? \_\_\_\_\_
4. How often does your child have a seizure? \_\_\_\_\_
5. Describe the seizure. \_\_\_\_\_
6. How long does the seizure last? \_\_\_\_\_
7. When was your child's last seizure? \_\_\_\_\_
8. Does your child know he/she is going to have a seizure before it occurs? \_\_\_\_\_
9. Describe your child's behavior after a seizure. \_\_\_\_\_
10. Please list the medications your child currently takes for seizures.

	Medication	Dose	Frequency
<b>In School</b>			
<b>At Home</b>			

If medications are to be given during school, a medication permission slip needs to be filled out yearly. Medications must be in original labeled container. (When you have prescriptions filled you can ask the pharmacist to put them in two containers so you'll have one for school and one for home use.)

11. What side effects does your child have from the medication? \_\_\_\_\_
12. Has your child been treated in the emergency room for seizures? \_\_\_\_\_
13. Does your child need special considerations related to seizures at school? \_\_\_\_\_
14. Please describe. \_\_\_\_\_  
\_\_\_\_\_

15. Have you ever attended seizure education class?     Yes     No
16. Has your child ever attended seizure education class?     Yes     No

Parent Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Cell Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Seizure Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_