

FORM 7 - SEIZURE MANAGEMENT & EMERGENCY RESPONSE PLAN

Name:

Date of Birth

Year: Form: Teacher:

Type/s of Seizures:

Date of first seizure: / /

Section A – Medication for Seizure Management – To be completed by parent/carer

1. Does your child require **medication** to be administered regularly at school? Yes No
2. If yes, complete the table below.
3. If no, proceed to **emergency medication** table and complete.

MEDICATION INSTRUCTIONS

	Medication 1	Medication 2	Medication 3
Name Of Medication			
Expiry Date			
Dose/Frequency – may be as per the pharmacist's label			
Duration (Dates)	From: To:	From: To:	From: To:
Route Of Administration			
Administration (Tick Appropriate Box)	By self <input type="checkbox"/> Requires assistance <input type="checkbox"/>	By self <input type="checkbox"/> Requires assistance <input type="checkbox"/>	By self <input type="checkbox"/> Requires assistance <input type="checkbox"/>
Storage Instructions (Tick appropriate box(es))	Stored at school <input type="checkbox"/> Kept and managed by self <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/> Other <input type="checkbox"/>	Stored at school <input type="checkbox"/> Kept and managed by self <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/> Other <input type="checkbox"/>	Stored at school <input type="checkbox"/> Kept and managed by self <input type="checkbox"/> Refrigerate <input type="checkbox"/> Keep out of sunlight <input type="checkbox"/> Other <input type="checkbox"/>

Are there any other precautions?

Section B: Seizure Management

Step 1	Remain calm Remain with the student
Step 2	Remove furniture or objects that could cause harm – Do not restrain
Step 3	Record the length of the seizure and what happens during the seizure
Step 4	Do not attempt to put anything into the child's mouth or between the teeth. (The exception is use of specified medications, such as buccal midazolam, therefore, administer emergency medication if indicated in Section D)
Step 5	When the seizure ceases, gently roll the student on to his/her side (recovery position)
Step 6	Stay with the student until he/she regains consciousness and establish communication

Section C: Emergency Management

Call an ambulance if:

- The seizure lasts more than 5 minutes
- Another seizure occurs immediately after the last
- The student sustains an injury
- If there is concern regarding cardio-respiratory status
- In doubt/concerned

Section D: Administration Of Emergency Medication

	Medication 1	Medication 2
Name Of Medication	_____	_____
Dose/Frequency	_____	_____
Route Of Administration	Buccal <input type="checkbox"/> Nasal <input type="checkbox"/> Rectal <input type="checkbox"/>	Buccal <input type="checkbox"/> Nasal <input type="checkbox"/> Rectal <input type="checkbox"/>
Expiry Date	____/____/____	____/____/____
Any other specific instructions?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please state below:	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please state below:
Storage Instructions (Tick appropriate box(es))	<ul style="list-style-type: none"> • Stored at school <input type="checkbox"/> • Refrigerate <input type="checkbox"/> • Keep out of sunlight <input type="checkbox"/> • Other (list) <input type="checkbox"/> 	<ul style="list-style-type: none"> • Stored at school <input type="checkbox"/> • Refrigerate <input type="checkbox"/> • Keep out of sunlight <input type="checkbox"/> • Other (list) <input type="checkbox"/>

Section E – Authority to Act

This seizure management and emergency response plan authorises the school staff to follow my/our advice and/or medical practitioner. It is valid for one year or until I/we advise the school of a change in my child's health care requirements.

Parent/Carer:
Date:

Medical Practitioner: (if required)
Date:

Review Date:

Name: _____ School: _____ DOB: _____

OFFICE USE ONLY

Date received _____ Date uploaded on SIS: _____

Is specific staff training required? Yes No : _____ Type of training: _____

Training service provider: _____

Name of person/s to be trained: _____ Date of training: _____

Complete only relevant sections and attach the student health care summary form to the front of this document