FORM 7 - SEIZURE MANAGEMENT & EMERGENCY RESPONSE PLAN

STUDENT DETAILS

SCHOOL:	YEAR: FORM:	INSERT PHOTO HERE
NAME:	DATE OF BIRTH:	
ADDRESS:	GENDER:	
FAMILY CONTACT DETAILS	TEACHER:	
NAME:	**MEDICAL DETAILS**	
ADDRESS:	DOCTOR :	
RELATIONSHIP TO STUDENT:	SPECIALIST:	TELEPHONE:
TELEPHONE: (W) (H) (M)	MEDICAL CENTRE:	
NAME:	HOSPITAL: TELEPHONE:	
ADDRESS:	PERMISSION IS GIVEN TO SEEK MEDICAL ATTENTION FOR MY CHILD AS REQUIRED FROM THE ABOVE MEDICAL CENTRE. YES ☐ NO ☐	
RELATIONSHIP TO STUDENT:	DO YOU HAVE AMBULANCE COVER? YES ☐ NO ☐ **IF THERE IS A MEDICAL EMERGENCY PARENTS/CARERS ARE EXPECTED TO MEET THE COST OF THE AMBULANCE.**	
TELEPHONE: (W) (H) (M)	**STUDENT HAS A MEDICALERT BRACELET/PENDANT** YES ☐ NO ☐ IF YES PROVIDE DETAILS:	

SECTION A – MEDICATION FOR SEIZURE MANAGEMENT – TO BE COMPLETED BY PARENT/CARER

TYPE/S OF SEIZURES: **DATE OF FIRST SEIZURE:** / /

DAILY MEDICATION REQUIREMENTS

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 INFORMATION

	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 REQUIRES ASSISTANCE**	☐ ☐	**BY SELF REQUIRES ASSISTANCE**	☐ ☐	**BY SELF REQUIRES ASSISTANCE**	☐ ☐
STORAGE INSTRUCTIONS (TICK APPROPRIATE BOX(ES)	**STORED AT SCHOOL**	☐	**STORED AT SCHOOL**	☐	**STORED AT SCHOOL**	☐
	KEPT AND MANAGED BY SELF	☐	**KEPT AND MANAGED BY SELF**	☐	**KEPT AND MANAGED BY SELF**	☐
	REFRIGERATE	☐	**REFRIGERATE**	☐	**REFRIGERATE**	☐
	KEEP OUT OF SUNLIGHT	☐	**KEEP OUT OF SUNLIGHT**	☐	**KEEP OUT OF SUNLIGHT**	☐
	OTHER	☐	**OTHER**	☐	**OTHER**	☐

ARE THERE ANY OTHER PRECAUTIONS?

PARENT/CARER SIGNATURE: _____ PRINCIPAL SIGNATURE: _____

DATE: / /

NAME: SCHOOL: DOB:

SECTION B: SEIZURE MANAGEMENT

STEPS	MANAGEMENT INSTRUCTIONS
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 MIDAZALAM)** **ADMINISTER EMERGENCY MEDICATION IF INDICATED BELOW.**
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 ☐ NASAL ☐ RECTAL ☐		BUCCAL ☐ NASAL ☐ RECTAL ☐	
EXPIRY DATE	___/_____/_____		___/_____/_____	
ANY OTHER SPECIFIC INSTRUCTIONS?	YES ☐ NO ☐ IF YES, PLEASE STATE BELOW		YES ☐ NO ☐ IF YES, PLEASE STATE BELOW	
STORAGE INSTRUCTIONS (TICK APPROPRIATE BOX(ES)	• STORED AT SCHOOL • REFRIGERATE • KEEP OUT OF SUNLIGHT • OTHER (LIST)	☐ ☐ ☐ ☐	• STORED AT SCHOOL • REFRIGERATE • KEEP OUT OF SUNLIGHT • OTHER (LIST)	☐ ☐ ☐ ☐

PARENT/CARER SIGNATURE: _____ PRINCIPAL SIGNATURE: _____

DATE: / /

NAME:	SCHOOL:	DOB:

SECTION D – STAFF TRAINING REQUIREMENTS

IS SPECIFIC TRAINING FOR STAFF REQUIRED TO MANAGE YOUR CHILD'S CONDITION OR NEEDS? (YOU MAY LIKE TO DISCUSS WITH THE PRINCIPAL).

A. FOR DAILY MANAGEMENT? YES ☐ NO ☐ IF YES, PLEASE DESCRIBE:

B. IN AN EMERGENCY? YES ☐ NO ☐ IF YES, PLEASE DESCRIBE:

SECTION E – AGREEMENT BETWEEN THE SCHOOL PRINCIPAL, THE PARENT/CARER AND MEDICAL PRACTITIONER – TO BE COMPLETED BY ALL

THE AGREEMENT AUTHORISES THE SCHOOL STAFF TO FOLLOW THE ADVICE OF THE STUDENT'S PARENT/CARER AND/OR MEDICAL PRACTITIONER AS SET OUT IN THIS PLAN. IT IS VALID FOR ONE YEAR OR UNTIL I ADVISE THE SCHOOL OF A CHANGE IN MY CHILD'S HEALTH CARE REQUIREMENTS.

PRINCIPAL: **DATE:**	**MEDICAL PRACTITIONER: (SIGNATURE REQUIRED)** **DATE:**
PARENT/CARER: **DATE:**	**REVIEW DATE:**

OFFICE USE ONLY

IS SPECIFIC STAFF TRAINING REQUIRED? **YES** ☐ **NO** ☐ DATE:

TYPE OF TRAINING:

NAME OF PERSON(S) TO BE TRAINED:

PRINCIPAL SIGNATURE:

COMPLETE ONLY RELEVANT SECTIONS AND ATTACH THE STUDENT HEALTH CARE SUMMARY FORM TO THE FRONT OF THIS DOCUMENT