

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.

INSTRUCTIONS FOR ADMINISTRATION OF REGULAR MEDICATION

	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	By self <input type="checkbox"/>	By self <input type="checkbox"/>	By self <input type="checkbox"/>
Tick Appropriate Box	Requires assistance <input type="checkbox"/>	Requires assistance <input type="checkbox"/>	Requires assistance <input type="checkbox"/>
Storage Instructions	Stored at school <input type="checkbox"/>	Stored at school <input type="checkbox"/>	Stored at school <input type="checkbox"/>
Tick appropriate box(es)	Kept and managed by self <input type="checkbox"/>	Kept and managed by self <input type="checkbox"/>	Kept and managed by self <input type="checkbox"/>
	Refrigerate <input type="checkbox"/>	Refrigerate <input type="checkbox"/>	Refrigerate <input type="checkbox"/>
	Keep out of sunlight <input type="checkbox"/>	Keep out of sunlight <input type="checkbox"/>	Keep out of sunlight <input type="checkbox"/>
	Other <input type="checkbox"/>	Other <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 may be the use of specified medications such as buccal midazolam which may need to be administered in an emergency 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 is able to communicate Advise parents/carers

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 the student's 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"/>

Name: _____ DOB: _____ Year: _____ Form: _____ Teacher _____

Section E – Authority to Act

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

Parent/Carer:
Date:

Medical Practitioner: (if required)
Date:

Review Date:

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:

When completed, please attach to the *Student Health Care Summary*