

**WASHINGTON YOUTH ACADEMY  
CARE PLAN/ EMERGENCY ACTION PLAN-SEIZURES**

Cadett's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age when diagnosed \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_ Phone #: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

What type of seizure does child have? \_\_\_\_\_ How often do the seizures occur? \_\_\_\_\_

How long has it been since his/her last seizure? \_\_\_\_\_

Does he/she experience an aura before having a seizure? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

| MEDICATION NAME | DOSE/ AMOUNT TAKEN | HOW OFTEN? | WILL MEDICATION BE NEEDED AND TAKEN AT SCHOOL? |
|-----------------|--------------------|------------|--|
|                 |                    |            |  |
|                 |                    |            |  |

Dose student have a Vagus Nerve Stimulator (VNS)? \_\_\_\_\_ Where is the magnet worn? \_\_\_\_\_

Describe use of the magnet: \_\_\_\_\_

**SIGNS OF SEIZURES: PLEASE CHECK BEHAVIORS THAT APPLY TO YOUR CHILD.**

| SIMPLE SEIZURES   | GENERALIZED SEIZURES   | DANGER SIGNS- CALL 911   | BEHAVIORS EXPECTED AFTER SEIZURE   |
|---|--|--|--|
| <input type="checkbox"/> Lip smacking<br><input type="checkbox"/> Behavioral outbursts<br><input type="checkbox"/> Staring<br><input type="checkbox"/> Twitching<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Sudden cry or squeal<br><input type="checkbox"/> Falling down<br><input type="checkbox"/> Rigidity/Stiffness<br><input type="checkbox"/> Thrashing/Jerking<br><input type="checkbox"/> Loss of bowel/bladder control<br><input type="checkbox"/> Shallow breathing<br><input type="checkbox"/> Stops breathing<br><input type="checkbox"/> Blue color to lips<br><input type="checkbox"/> Froth from mouth<br><input type="checkbox"/> Gurgling or grunting noises<br><input type="checkbox"/> Loss of consciousness<br><input type="checkbox"/> Other: _____ | <ul style="list-style-type: none"> <li>• Seizure lasts more than 5 minutes</li> <li>• Another seizure starts right after the 1<sup>st</sup> seizure</li> <li>• Loss of consciousness</li> <li>• Stops breathing</li> <li>• If student has diabetes</li> <li>• If seizure is the result of an injury or child is injured during seizure</li> <li>• If student is pregnant</li> <li>• If student has never had a seizure before</li> </ul> | <ul style="list-style-type: none"> <li>• Tiredness</li> <li>• Weakness</li> <li>• Sleeping, difficult to arouse</li> <li>• Somewhat confused</li> <li>• Regular breathing</li> <li>• Other: _____</li> </ul> <p><b>ALL OF ABOVE CAN LAST A FEW MINUTES TO A FEW HOURS.</b></p> |

| IF YOU SEE THIS                   | DO THIS   |
|-----------------------------------|---|
| SEIZURE ACTIVITY                  | Stay calm. Move surrounding objects to avoid injury. Do <u>not</u> hold the student down or put anything in the mouth. Loosen clothing as able. After seizure stops, roll student on his/her side. <b>Document seizure activity on back of this form.</b> If applicable, administer medications as ordered. Notify their parent/guardian and school RN. |
| STOPS BREATHING                   | Begin CPR/Rescue breathing. Call 911  |
| LOSS OF BOWEL OR BLADDER CONTROL  | Cover with blanket or jacket. If necessary: discreetly assist with changing of clothes after seizure.   |
| DANGER SIGNS-SEE ABOVE            | Call 911. Then call parent/guardian.  |
| FALLS DOWN, LOSS OF CONSCIOUSNESS | Help student to the floor for observation and safety  |
| VOMITING                          | Turn on side  |
| <b>SIGNATURES</b>                 | <b>DATE</b> <b>PARENT SIGNATURE</b> <b>NURSE SIGNATURE</b>  |
| PLAN INITIATED                    |   |

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Name of Cadet: \_\_\_\_\_ Platoon: \_\_\_\_\_

NOTE: This should be accompanied by a *Seizure Care Plan* established and on-file for this child.

| DATE | TIME | DESCRIBE SEIZURE* | CIRCUMSTANCES PRECEEDING (activity participating in) | DESCRIBE SEIZURE+ LENGTH OF SEIZURE | ACTIONS TAKEN BY STAFF | CHILD'S BEHAVIOR AFTER SEIZURE | STAFF INITIALS |
|------|------|-------------------|--|-------------------------------------|------------------------|--------------------------------|----------------|
|      |      |                   |  |                                     |                        |                                |                |
|      |      |                   |  |                                     |                        |                                |                |
|      |      |                   |  |                                     |                        |                                |                |
|      |      |                   |  |                                     |                        |                                |                |
|      |      |                   |  |                                     |                        |                                |                |
|      |      |                   |  |                                     |                        |                                |                |
|      |      |                   |  |                                     |                        |                                |                |

**\*What To Look For and Note Above:**

- How did the seizure start? Did the seizure start in just one part of the body and then spread, or did it involve the whole body from the beginning?
- Was there smacking or licking of the lips? Eyelid fluttering? Picking or fumbling movements of the hands?
- Was the child able to respond to any outside stimulus (for example, name called, gently shaking shoulder)? Was the response normal/confused/no response?
- Were there stiff and/or jerking movements?
- Was the jaw clenched or the tongue bitten?
- Was there any color change or breathing problem?
- How long did the actual seizure last?

**Symptoms**

**Absence (Petit mal):**

- Brief loss of consciousness
- Minimal or no alteration in muscle tone
- Usually able to maintain postural control
- Minor movements or twitches
- May be mistaken for inattention

**Tonic-Clonic (Grand mal):**

- Loss of consciousness-child falls to floor or ground
- Breathing may stop momentarily
- Arms and legs may become rigid and move in rhythm
- May be incontinent of urine or feces
- May last several minutes
- May want to sleep afterwards