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 Requires assistance	☐ ☐	By self Requires assistance	☐ ☐	By self Requires assistance	☐ ☐
Storage Instructions (Tick appropriate box(es)	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐

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 midazalam, 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 ☐ 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)	☐ ☐ ☐ ☐

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:	Date of Birth	Year:	Form:	Teacher:

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