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. (**Note**: All medication must be provided by parents/carers)
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 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 may be the use of specified medications such as buccal midazalam which may meed 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 ☐ 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) ☐

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*