

# Medical History & Physician Prescribed Emergency Seizure Treatment Order

(To Be Completed by Child's Physician)



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## History

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_

Seizure Types \_\_\_\_\_ Description \_\_\_\_\_

Allergies \_\_\_\_\_ Treatment Order Date \_\_\_\_\_

## Treatment Order:

- Rescue medication \_\_\_\_\_ mg rectally prn for:  
seizure > \_\_\_\_\_ minutes OR for \_\_\_\_\_ or more seizures in \_\_\_\_\_ hours
- Use VNS (vagal nerve stimulator) magnet \_\_\_\_\_
- Other \_\_\_\_\_
- Call 911 if:
  - Seizure does not stop by itself or with VNS within \_\_\_\_\_ minutes
  - Seizure does not stop within \_\_\_\_\_ minutes of administering rescue medication
  - Child does not start to wake up within \_\_\_\_\_ minutes after seizure is over (no rescue medication given)
  - Child does not start to wake up within \_\_\_\_\_ minutes after seizure is over (after rescue medication given)
- Following a seizure: (Please check off)
  - Child should rest in nurse's office
  - Child may return to class
  - Parents/Caregiver should be notified immediately
  - Parents/caregiver should receive a copy of the seizure record sent home with the child

## Physician Information:

Physician/Nurse Practitioner/Physician Assistant Name (Printed) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

License Number \_\_\_\_\_ State \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax \_\_\_\_\_

*Developed in collaboration with Christine O'Dell, RN, MSN and Shlomo Shinnar, MD, PhD, of the Comprehensive Epilepsy Management Center, Montefiore Medical Center, Bronx, New York.*

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# Emergency Seizure Treatment Step-by-Step

## Step 1. Confirm seizure

### Signs and Symptoms

When I am having a seizure, I might display some of the following signs or symptoms:

- Convulsions
- Stiffening
- Unconsciousness
- Staring
- Involuntary rhythmic movements
- Other \_\_\_\_\_

## Step 2. Provide basic first aid

To ensure my safety, here are some steps to follow:



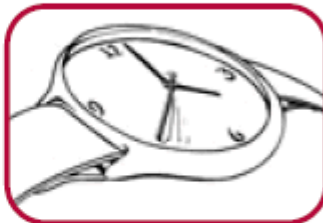
1. Cushion head, remove glasses.



2. Loosen tight clothing.



3. Turn on side and keep airway clear.



4. Note the time a seizure starts and the length of time it lasts.



5. Don't put anything in mouth.



6. Don't hold down.

7. As seizure ends...offer help.

## Step 3. Treatment options

Please record important information on the seizure log cards on the next page.

If I don't regain consciousness within \_\_\_\_\_ minutes, please:

- Call 911
  - Once 911 is called, please call my emergency contacts below
- If this box is checked advise EMTs that I have a VNS magnet

OR

- Administer rescue medication
  - For seizures that last more than \_\_\_\_\_ minutes OR for \_\_\_\_\_ or more seizures in \_\_\_\_\_ hours
  - My rescue medication is kept: \_\_\_\_\_

### Call 911 if

- I do not start waking up within \_\_\_\_\_ minutes after seizure is over (after giving rescue medication)
- Seizure does not stop within \_\_\_\_\_ minutes of giving rescue medication

## Step 4. Notification

Call the following people if:

- I go to the Emergency Room
- You are concerned about my response
- Rescue medication is administered
- Other \_\_\_\_\_

### Emergency Contacts

Name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

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## Plan-at-a-Glance Wallet Cards

**First Aid Steps for Convulsions or Seizures**

- Cushion head, remove glasses
- Loosen tight clothing
- Turn on side and keep airway clear
- Note the time a seizure starts and the length of time it lasts
- Don't put anything in mouth
- Don't hold down
- As seizure ends, offer help

My name is \_\_\_\_\_

**I am experiencing an epileptic seizure**

**Please notify:**

Family \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Physician \_\_\_\_\_  
 Phone \_\_\_\_\_

**If I am injured or unconscious for more than 5 minutes please call 911**

Additional emergency information on other side.

**First Aid Steps for Convulsions or Seizures**

- Cushion head, remove glasses
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**If I am injured or unconscious for more than 5 minutes please call 911**

Additional emergency information on other side.

**Emergency Process Plan**  
 Seizure Information

See other side for First Aid and Contact Information

Name \_\_\_\_\_  
 Date of birth \_\_\_\_\_  
 Current medication(s) \_\_\_\_\_  
 Allergies \_\_\_\_\_  
 Seizure type(s) \_\_\_\_\_  
 Frequency of seizures \_\_\_\_\_  
 Description \_\_\_\_\_  
 Seizure usually lasts \_\_\_\_\_ minutes  
 Usually recover in \_\_\_\_\_ minutes  
 Treatment for seizure \_\_\_\_\_

**Seizure Treatment**

- Administer rescue medication \_\_\_\_\_ mg for seizure > \_\_\_\_\_ minutes or for \_\_\_\_\_ or more seizures in \_\_\_\_\_ hours
- Use VNS magnet \_\_\_\_\_
- Other \_\_\_\_\_
- Call 911 if \_\_\_\_\_
- Seizure does not stop by itself or with VNS within \_\_\_\_\_

**Emergency Process Plan**  
 Seizure Information

See other side for First Aid and Contact Information

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 Date of birth \_\_\_\_\_  
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- Other \_\_\_\_\_
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- Seizure does not stop by itself or with VNS within \_\_\_\_\_

minutes

• Seizure does not stop within \_\_\_\_ minutes of giving rescue medication

• I do not start waking up within \_\_\_\_ minutes after seizure is over

(no rescue medication given)

• I do not start waking up within \_\_\_\_ minutes after seizure is over

(after rescue medication given)

Other

\_\_\_\_\_

Following a seizure

\_\_\_\_\_

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minutes

• Seizure does not stop within \_\_\_\_ minutes of giving rescue medication

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Other

\_\_\_\_\_

Following a seizure

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# Student Interview Form

(for the school nurse)

**Purpose:** To help you establish a relationship with the student. This interview will also assist you in gathering additional medical information that will help manage his or her health throughout the year.

**How to use:** Set up 1/2 hour to meet with the student and use this form as a discussion guide.

Student's name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

School \_\_\_\_\_ Teacher \_\_\_\_\_ Classroom \_\_\_\_\_

How old were you when your seizures began? \_\_\_\_\_

Do you have any special feelings before a seizure? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Not sure

If yes, please explain \_\_\_\_\_

What do you think happens during your seizures? \_\_\_\_\_

How do you feel after a seizure? \_\_\_\_\_

What medication(s) do you take? (You may need to ask the parent/caregiver for this information.)

Medication	Dosing	Schedule
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who gives you your medications at home? \_\_\_\_\_

**If medication is self-administered, then ask:**

Do you remember to take your medication on your own? \_\_\_\_\_

Do you do anything special to remember to take your medication? \_\_\_\_\_

What do you do if you miss a dose? \_\_\_\_\_

Do you feel any different if you miss a dose? \_\_\_\_\_

What things (if any) seem to bring on a seizure? (list) \_\_\_\_\_

How often do you have seizures? \_\_\_\_\_

Is there a time of day or situation when they occur most often? \_\_\_\_\_

When was your last seizure? \_\_\_\_\_

Besides taking medication, how do you control your seizures? \_\_\_\_\_

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What special problems (if any) do you have in school that you feel are related to your epilepsy?

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Have you told any of your friends about your seizures? (If yes, what did you tell them, when, and how did they react?)

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Have you told any of your teachers you have seizures? (If yes, what did you tell them, when, and how did they react?)

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If you have a seizure at school, what would you like the following people to do for you?

School nurse \_\_\_\_\_

Teacher(s)/Coach(es) \_\_\_\_\_

Classmates \_\_\_\_\_

Date completed \_\_\_\_\_

Date updated \_\_\_\_\_

Notes \_\_\_\_\_

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## Seizure Record

This Log To Be Completed by Child's School Nurse and Returned to Parents/Caregivers After a Seizure

*Please Duplicate as Needed*

**Purpose:** A Seizure Log is used to track any pre-seizure activity, the number and duration of seizures and any post-seizure activity.

**How to use:** After being completed, a copy should be sent home for the parents'/caregiver's records.

**Note:** Use only 1 form per seizure. Duplicate as needed.

Student's name \_\_\_\_\_ Date of report \_\_\_\_\_

Event	Time
Seizure start time: _____	_____
Rescue Medication Administration Time (if prescribed by physician): _____	_____
VNS (vagal nerve stimulator) magnet (if prescribed by physician): _____	_____
Other treatments: (if prescribed by physician): _____	_____
911 called (if needed): _____	_____
Seizure end time: _____	_____

Where was the child when the seizure occurred?

\_\_\_\_\_

Activities immediately preceding the seizure \_\_\_\_\_

\_\_\_\_\_

Noteworthy behavior immediately preceding the seizure \_\_\_\_\_

\_\_\_\_\_

Description of seizure behavior \_\_\_\_\_

\_\_\_\_\_

Behavior after the seizure \_\_\_\_\_

\_\_\_\_\_

Were there any injuries? \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_

If yes, describe \_\_\_\_\_

\_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**After the Seizure**

Check any side effects you may have observed and add relevant details.

- Drowsiness
- Slurred speech
- Irritability
- Nausea
- Confusion
- Unsteady walk
- Inattention
- Poor memory

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

School nurse signature \_\_\_\_\_

School nurse phone \_\_\_\_\_

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