717 JORDAN PUBLIC SCHOOLS
Jordan Elementary School
815 Sunset Drive
Jordan, Minnesota 55352
952-492-2336 main | 952-492-4446 fax

NICOLE LANGHEIM | *RN, BSN, PHN, LSN*
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District Nurse
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RE: SEIZURE EMERGENCY CARE PLAN

Dear Parent(s) Guardians of: _____

According to our recent records you have indicated that your child has a history of seizures. To best care for your child while he/she is in school, please fill out the **"Seizure Questionnaire"** and have his/her physician fill out the **"Seizure Emergency Care Plan"** before the start of the school year.

The forms on the following pages must be completed and signed before the start of school.

Please return the enclosed forms as soon as possible either by mailing, faxing or in person at the following school so that we may best care for your child should the need arise:

_____ **Jordan Elementary School**	Address: 815 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4446
_____ **Jordan Middle School**	Address: 500 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4450
_____ **Jordan High School**	Address: 600 Sunset Drive, Jordan, MN 55352 Fax: 952-492-4425

Please call or email us if you have any questions or concerns.

Thank you,

Laura Menden RN, LSN
Nicole Langheim RN, LSN
District Nurses (JES)
952-492-4278
jordannurse@isd717.org

Kelley Harmon LPN (JMS)
952-492-4232
kharmon@isd717.org

Kathy Dunham LPN (JHS)
952-492-4410
kdunham@isd717.org

Seizure Questionnaire
Independent School District 717

Student Name: _____ DOB: _____

Grade: _____ Teacher: _____

SEIZURE HISTORY

1. What type of seizures does your child experience? **Please check all that apply:**

   - ☐ **Simple Partial** -- Remains conscious, twitching or numb sensation, usually lasting less than 30 seconds.
   - ☐ **Complex Partial** -- Altered consciousness, transient staring, feelings of unreality and detachment. May have hallucinations, unexplained feelings of fear, disrupted memory, teething grinding, lip smacking, chewing, swallowing, scratching or pulling at buttons. Lasts usually no longer than 1-2 minutes.
   - ☐ **Tonic-Clonic** -- Abrupt arrest of activity, loss of consciousness, symmetrical and rhythmical alterations of contraction and relaxation of major muscle groups. Ends suddenly in less than 5 minutes.
   - ☐ **Atonic** -- Abrupt loss of postural tone, loss of consciousness, confusion, lethargy and sleep. (May just fall asleep suddenly; when laughing, the child may fall down.)
   - ☐ **Myoclonic** -- Brief random contractions of a muscle group, may occur on one side of the body, no loss of consciousness.
   - ☐ **Absence** -- Very brief periods of altered awareness, eyelids may flutter or twitch, blank facial expression, lasts 5-10 seconds but can occur repeatedly.
   - ☐ **Tonic** -- Lack of movement, stiffening of the entire body musculature, arms flex, legs, neck and head extend. Peculiar, piercing cry, cyanosis (bluish coloring to skin), may temporarily stop breathing, increased salivation.
   - ☐ **Akinetic** -- No movement, but muscle tone is maintained. Like "freezing into position," may lose consciousness.

2. What triggers have been identified (if any)?_____
3. When was the last time your child had a seizure?_____
4. When was the last time emergency seizure medication was given?_____
5. How long do seizures typically last?_____
6. Does your child recognize the signs of an impending seizure? ☐ Yes ☐ No
7. Is your child able to alert an adult if he/she feels a seizure is about to happen? ☐ Yes ☐ No
8. List daily seizure medication (if any)_____

Parent Name _____(h) _____ (w) _____ (c)_____

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Seizure Emergency Care Plan

Student Name: _____ DOB: _____ Grade: _____

In case of a seizure:

- **STAY CALM** and time the seizure if able to see a clock
- Assist student to the floor and place them on their side
- Clear area to protect student from injury
- Do not put anything in mouth
- Loosen any tight clothing that may impede breathing
- Do not try to stop the seizure or hold student down
- If a febrile seizure, be sure to cool the student down with cool cloths
- **CALL 911 IF**: seizure activity is different from "usual seizure activity", child's breathing is affected or child fails to regain consciousness after seizure activity has stopped.
- **FOLLOW DOCTORS ORDERS AS WRITTEN BELOW**

PHYSICIAN ORDERS

Emergency Medication Orders

Give EMERGENCY MEDICATION if seizure lasts LONGER than _____ minutes

Emergency Medication Name _____ Dose_____ Route _____

Frequency_____

Call 911 if _____

Other instructions_____

_____

Physician Signature_____**Date**_____

I want this plan implemented for my child while in school. I give permission for exchange of confidential medical information between school staff and my child's health care providers on a need to know basis. I release school personnel from liability in the event adverse reactions result from implementation of the above emergency plan and subsequent administration of emergency medication(s). I give permission for school staff to call 911 if necessary.

Parent Name _____(h) _____ (w) _____ (c)_____

Parent Name _____(h) _____ (w) _____ (c)_____

Emergency Contact _____(h) _____ (w) _____ (c)_____

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____