SEIZURE FIRST AID INSTRUCTIONS FOR SCHOOL NURSE AND TEACHER INFORMATION SHEET

Information Section

Student Name		**DOB**		
School:		Teacher:		
Physician:		Phone:		
Emergency Contacts				
Name	Relationship	Home Phone	Work Phone	Cell Phone

MEDICAL TREATMENT PRESCRIBED IF A SEIZURE OCCURS

❑ **VAGUS NERVE STIMULATOR: SWIPE MAGNET OVER DEVICE (DEVICE IS LOCATED UNDER THE SKIN OF UPPER LEFT CHEST: REMOVE THE MAGNET, YOU MAY REPEAT EVERY ONE TO TWO MINUTES UNTIL SEIZURE RESOLVES).**

❑ **DIASTAT (RECTAL DIAZEPAM): Administer _____mg ___ minutes after onset of seizure.**

Green Zone **< 2 minutes**	**Yellow Zone** **2 to 5 minutes**	**Red Zone** **More than 5 minutes or if 2 or more consecutive seizures total 10 minutes or more**
✷ Begin FIRST AID ✷ Swipe VNS Magnet if ordered ✷ Allow student to recover from seizure ✷ Notify parent/guardian and return to class or to home as instructed by parent/guardian	✷ Continue FIRST AID ✷ Call for help ✷ Re-swipe VNS magnet ✷ Prepare to administer Diastat (if Diastat is to be given, remove other students from room) ✷ Allow student to recover from seizure ✷ Notify parent/guardian and return to class or to home as instructed by parent/guardian	✷ Call 911 ✷ Administer Diastat if ordered ✷ Notify parent/guardian ✷ Monitor respirations and heart beat and start CPR if needed ✷ Continue FIRST AID

Physician Signature	**Date**
Print Name	**Phone**

PARENTAL PERMISSION:

I hereby request the school personnel, or its agents, to assist in the seizure management procedure for my child as prescribed by the doctor. I understand that there is no liability on the part of the school district, its agents or its personnel for civil damages as a result of assisting with this procedure when the person acts as an ordinarily reasonable and prudent person would have acted under the same or similar circumstances.

I want this plan implemented for my child, ____________________________________, while at school. I give my permission for exchange of confidential information contained in the record of my child between the nurse and physician and my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

Parent/Guardian Signature	**Date**
Print Name	**Phone**