INSTRUCTIONS FOR COMPLETING THE

SEIZURE MEDICAL ACTION PLAN

Dr. must sign, date AND stamp this form in order for it to be accepted by CYSS. Please note that the action plan is good for 12 months from the date that the Dr. signs them.

1. **Parents** should fill out the top portion of the form.
2. **Dr.** should fill out whether the child has a history of febrile seizures or not. If yes, the Dr. will fill out the following section on Febrile Seizure Prevention. Dr. should also fill in whether Tylenol or Motrin should be given as well as the dose.
3. **Dr.** should fill in the symptoms of a seizure in the Seizure Information section of this form.
4. **Dr.** must sign, date AND stamp this form.
5. **Parents** must sign this form as well.

Medication must have current prescription label with clear directions on it.

CYS SERVICES SNAP SEIZURE MEDICAL ACTION PLAN

(to be completed by Health Care Provider)

Child/Youth's Name	Date of Birth	Date
Sponsor Name		
Health Care Provider	Health Care Provider Phone	

Does child have a history of febrile seizures? □ **Yes** □ **No**
If yes, complete Febrile Seizure Prevention Plan below

Febrile Seizure Prevention Plan (CYS staff is not authorized to administer injections or rectal medication)

If temperature is equal to or greater than _____ axilliary

Then give: (Only Prescribed Tylenol or Motrin by mouth may be given in a CYS Services Setting)_____ as written on the prescription label.

CYS Services staff/providers are to notify parent/guardian for immediate pick up if medication is given.

Seizure Information

□ Lip Smacking	□ Wandering	□ Sudden Cry or Squeal	□ Thrashing/Jerking
□ Eye Rolling	□ Behavioral Outbursts	□ Rigidity or Stiffness	□ Blue Color to Lips
□ Staring	□ Falling Down	□ Froth from Mouth	□ Loss of Consciousness
□ Twitching	□ Shallow Breathing	□ Gurgling/Grunting	

□ Other _____

Emergency Response

CALL 911 AND PARENT

- Stay calm and track the time (beginning and ending time of seizure)
- Call another staff member to activate emergency response (911/calling parents)
- Place individual on flat surface
- Keep individual safe
- Do NOT restrain
- Do NOT place anything in individual's mouth
- Roll individual to side (this will decrease risk of choking)
- Stay with individual until EMS arrives
- Staff member will accompany individual to medical facility until parents arrive

Approving Signatures

I agree with the plan outlined above.

_____ _____
Parent/Guardian Printed Name and Signature — Date (YYYYMMDD)

_____ _____
Health Care Provider Signature **and Stamp** — Date (YYYYMMDD)
(This signature serves as the exception to medication policy)

_____ _____
Army Public Health Nurse Printed Name and Signature — Date (YYYYMMDD)

Follow Up

This Seizure Medical Action Plan must be updated/revised whenever medications or child/youth's health status changes. If there are no changes, the Seizure Medical Action Plan must be updated every 12 months.

Form Updated 21 Jul 09