

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.

CONFIDENTIALITY STATEMENT

By creating and distributing this Pediatric Seizure Preparedness Plan, it is the expressed intention of Valeant Pharmaceuticals North America to provide a value-added service to healthcare providers, caregivers, and patients. Valeant Pharmaceuticals North America intends to fully comply with HIPPA guidelines for patient confidentiality to ensure that personal information is not disclosed to anyone outside of those that the parent/caregiver, healthcare professional, or student-patient deem acceptable. Valeant Pharmaceuticals North America is not responsible for this Plan or its contents after the Plan has been released to healthcare professionals. Careful consideration should be given before any medical information is released to others.

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:



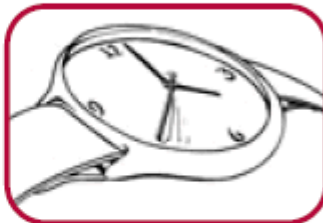
1. Cushion head, remove glasses.



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.

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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 _____

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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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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? _____

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

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

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

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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