CYS SERVICES SNAP SEIZURE MEDICAL ACTION PLAN

Updated May 2016

(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.

If, no provide information on prescribed seizure medications, seizure information or if no medications are indicated.

Febrile or other Seizure Prevention Plan

☐ For Febrile Seizures:

If temperature is equal to or greater than _____ axillary

Then give: Prescribed Tylenol or Motrin by mouth as written on the prescription label.
(circle one)

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

☐ For Non-Febrile Seizures:

Give Diastat as written on the prescription label.

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

☐ No medications indicated for child, follow emergency response procedures below.

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
(This signature serves as the exception to medication policy)

_____ Date (YYYYMMDD)

_____ 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.