

CYS SERVICES SNAP SEIZURE MEDICAL ACTION PLAN

(to be completed by Health Care Provider)

Child/Youth's Name	Date of Birth	Date
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Sponsor Name

Health Care Provider	Health Care Provider Phone
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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 _____ axillary

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

- | | | | |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Lip Smacking | <input type="checkbox"/> Wandering | <input type="checkbox"/> Sudden Cry or Squeal | <input type="checkbox"/> Thrashing/Jerking |
| <input type="checkbox"/> Eye Rolling | <input type="checkbox"/> Behavioral Outbursts | <input type="checkbox"/> Rigidity or Stiffness | <input type="checkbox"/> Blue Color to Lips |
| <input type="checkbox"/> Staring | <input type="checkbox"/> Falling Down | <input type="checkbox"/> Froth from Mouth | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Twitching | <input type="checkbox"/> Shallow Breathing | <input type="checkbox"/> Gurgling/Grunting | |
| <input type="checkbox"/> 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.

Form Updated 21 Jul 09