FORM 7 - SEIZURE MANAGEMENT & EMERGENCY RESPONSE PLAN

Name: ____________________________  Date of Birth: ____________________________
Year: ____________________________  Form: ____________________________  Teacher: ____________________________

**Section A – Medication for Seizure Management – To be completed by parent/carer**

1. Does your child require medication to be administered regularly at school?  
   Yes [ ]  No [ ]

2. If yes, complete the table below. (Note: All medication must be provided by parents/carers)

3. If no, proceed to emergency medication table and complete.

**INSTRUCTIONS FOR ADMINISTRATION OF REGULAR MEDICATION**

<table>
<thead>
<tr>
<th>Name Of Medication</th>
<th>Medication 1</th>
<th>Medication 2</th>
<th>Medication 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expiry Date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose/Frequency – (may be as per the pharmacist’s label)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration (Dates)</td>
<td>From:</td>
<td>From:</td>
<td>From:</td>
</tr>
<tr>
<td></td>
<td>To:</td>
<td>To:</td>
<td>To:</td>
</tr>
<tr>
<td>Route Of Administration</td>
<td>By self Requires assistance</td>
<td>By self Requires assistance</td>
<td>By self Requires assistance</td>
</tr>
<tr>
<td>Administration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tick Appropriate Box</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Storage Instructions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tick appropriate box(es)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are there any other precautions?

**Section B: Seizure Management**

Step 1  Remain calm
   Remain with the student

Step 2  Remove furniture or objects that could cause harm – Do not restrain

Step 3  Record the length of the seizure and what happens during the seizure

Step 4  Do not attempt to put anything into the child’s mouth or between the teeth. (The exception may be the use of specified medications such as buccal midazalam which may need to be administered in an emergency if indicated in Section D)

Step 5  When the seizure ceases, gently roll the student on to his/her side (recovery position)

Step 6  Stay with the student until he/she regains consciousness and is able to communicate
   Advise parents/carers

**Section C: Emergency Management**

**Call an ambulance if:**
- The seizure lasts more than 5 minutes
- Another seizure occurs immediately after the last
- The student sustains an injury
- If there is concern regarding the student’s cardio-respiratory status
- In doubt/concerned

**Section D: Administration Of Emergency Medication**

<table>
<thead>
<tr>
<th>Name Of Medication</th>
<th>Medication 1</th>
<th>Medication 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose/Frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Route Of Administration</td>
<td>Buccal [ ] Nasal [ ] Rectal [ ]</td>
<td>Buccal [ ] Nasal [ ] Rectal [ ]</td>
</tr>
<tr>
<td>Expiry Date</td>
<td>/ /</td>
<td>/ /</td>
</tr>
</tbody>
</table>

Any other specific instructions?  
Yes [ ] No [ ] If yes, please state below:  
Yes [ ] No [ ] If yes, please state below:

Storage Instructions (Tick appropriate box(es))
- Stored at school [ ]
- Refrigerate [ ]
- Keep out of sunlight [ ]
- Other (list) [ ]

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Section E – Authority to Act

This seizure management and emergency response plan authorises school staff to follow my/our advice and/or that of our medical practitioner. It is valid for one year or until I/we advise the school of a change in my/our child’s health care requirements.

Parent/Carer: ______________________________ Medical Practitioner: (if required) ______________________________ Review Date: ______________________________
Date: ______________________________ Date: ______________________________

OFFICE USE ONLY

Date received: ______________________________ Date uploaded on SIS: ______________________________
Is specific staff training required? Yes ☐ No ☐: ________________ Type of training: ______________________________
Training service provider: ______________________________
Name of person/s to be trained: ______________________________ Date of training: ______________________________

When completed, please attach to the Student Health Care Summary Form 7 page 2 of 2