

# 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 \_\_\_\_\_ 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