SEIZURE ACTION PLAN

CHILD'S NAME: _____ D.O.B.: _____

Description of seizure condition/disorder: _____

_____

_____

Describe what your child's seizures look like: (1) what part of the body is affected? (2) How long does it last?

_____

_____

Describe any known "triggers" (behavior and/or symptoms) for seizure activity: _____

_____

Detail the time and duration of child's typical seizure activity: _____

_____

Has the child been treated in the emergency room due to seizures? ○ Yes ○ No How many times? ____
Has the child stayed overnight in the hospital due to their seizures? ○ Yes ○ No How many times? ____

Planned strategies to support the child's needs and safety issues when a seizure occurs:
(diapering/toileting, outdoor play, nap/sleeping, etc.) _____

_____

PROBLEM	TREATMENT	EXPECTED RESPONSE
At risk for injury due to uncontrolled seizure activity.	If seizure occurs, staff will remove objects from the area and place a folded towel/clothing beneath the child's head. Protective helmet is worn if prescribed.	Decrease possibility of injuries related to seizure activity.
At risk for aspiration of respiratory secretions or vomiting during seizure activity	If a seizure occurs, staff will roll the child onto his/her side.	Decrease possible aspiration during seizure activity.
Self esteem disturbance related to occurrence of seizure or use of protective helmet.	Provide many opportunities for success. Praise achievements and accomplishments. Provide opportunities for child to express feelings about seizures and any reactions. Reassure the other children in the group that the child will be all right if a seizure occurs.	Increase child's successful adaptation to requirements of living with a seizure disorder. The child will demonstrate a positive attitude toward learning activities. Other children will feel safe.
Parent and child may not be aware of possible triggers.	Staff will document the occurrences of any seizure activity on an incident report.	Parent, staff and the child will learn to identify triggers and how to avoid them.
Child may be very sleepy, but not unresponsive after a seizure occurs.	Staff will make sure that the child is responsive after seizure, then the child will be allowed to sleep and/or rest after seizure.	The child may safely sleep/rest if needed, after seizure occurs.

Medications to be administered: ○ Yes ○ No *specify administration method, time schedule, side effects*
Type of medication: _____

_____

Additional Information: *(include any unusual episodes/behavior changes that might arise while in care and how the situation should be handled)*

_____

_____

Emergency Procedure
Call 911 if: ○ seizure is longer than _____ minutes ○ child is unresponsive after seizure
○ color changes ○ other: _____
Emergency Contact: _____ Phone: _____
This Seizure Action Plan will be updated/revised whenever medications of and/or child's health status changes.

Parent Signature _____ Date _____

If this or any other medical form is not applicable please write N/A on the page and sign.
Si esta o cualquier otra forma médica no es aplicable por favor escriba N/A en la página, y firme.

ALLERGY ACTION PLAN

CHILD'S NAME: _____ D.O.B.: _____

Does your child have any allergies? If yes, please specify

☐ **Yes** ☐ **No** (Specify details of any allergies and medications below)

_____

_____

Does your child carry an Epipen? ☐ **Yes** ☐ **No**

SALM does not provide or have these available and should be obtained by prescription through your family doctor.

ASTHMATIC ☐ **Yes** ☐ **No** **High risk for severe reaction

Check signs of allergic reaction pertinent to your child

☐	MOUTH	Itching and swelling of the lips, tongue or mouth
☐	THROAT	Itching and/or a sense of tightness in the throat, hoarseness and Hacking cough
☐	SKIN	Hives, itchy rash and /or swelling about the face or extremities
☐	STOMACH	Nausea, abdominal cramps, vomiting and/or diarrhea
☐	LUNG	Shortness of breath, repetitive coughing and/or wheezing
☐	HEART	Thready pulse, passing out

ACTION FOR MINOR REACTION:

1. If symptoms are: _____, give my child _____
   Medication/dose/route

Then call:

2. Mother _____, Father _____ or emergency contact
3. Dr. _____ at _____

If condition does not improve within ten minutes, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION:

1. If ingestion/contact is suspected and/or symptom(s) are:_____
   _____ give _____ IMMEDIATELY!
   Medication/dose/route

Then call 911

2. Rescue Squad (ask for advanced life support)
3. Mother _____, Father_____ or emergency contact
4. Dr. _____ at _____

Parent Signature _____ Date _____

Physician's Signature _____ Date _____

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ASTHMA ACTION PLAN

Child Name: _____ D.O.B.:_____

Severity Classification		Triggers		Exercise
○ Mild Intermittent	○ Moderate Persistent	○ Colds	○ Weather	1 Pre-medication (how much and when)
○ Mild Persistent	○ Severe Persistent	○ Exercise	○ Animals	_____
		○ Dust	○ Food	2 Exercise Modifications
		○ Smoke	○ Air Polution	_____
		○ Other _____		_____

GREEN ZONE: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Control Medications

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

More than 80% of personal best or _____

YELLOW ZONE: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Continue Control Medications and add:

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

Between 50 to 80% of personal best or _____ to _____

If your symptoms (and peak flow, if used) return to Green zone after one hour of the quick relief treatment, THEN

○ Take quick-relief medication every 4 hours for 1 to 2 days
○ Change your long-term control medicines by _____
○ Contact your physician for follow-up care

If your symptoms (and peak flow, if used) DO NOT return to GREEN ZONE after 1 hour of the quick treatment, THEN

○ Take quick-relief treatment again
○ Change your long-term control medicines by _____
○ Contact your physician within ____ hours of modifying your medication routine

RED ZONE: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Continue Control Medications and add:

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Peak Flow Meter

Between 0 to 50% of personal best or _____ to _____

Go to the hospital or call for an ambulance if

○ Still in the red zone after 15 minutes
○ If you have not been able to reach your physician for help

_____

Call an ambulance immediately if the following danger signs are present

○ Trouble walking/talking due to shortness of breath
○ Lips or fingernails are blue

Parent Signature _____ Date _____

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I ______________________________________ the parent and/or guardian of
Parent/Legal Guardian Name

__________________________________, authorize the staff of Shake-A-Leg Miami,
Student's Name

Inc. to administer the following designated medication to my child.

Name of Medication(s): ____

**Please note: Any perscription to be administered must be provided in the original bottle with label, instructions, and dosage information.*

Describe the circumstances under which the medication is to be administered:

Dosage administered will be according to prescription label: Time: ______________

Name of Medication(s): ____

**Please note: Any perscription to be administered must be provided in the original bottle with label, instructions, and dosage information.*

Describe the circumstances under which the medication is to be administered:

Dosage administered will be according to prescription label: Time: ______________

Name of Medication(s): ____

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Dosage administered will be according to prescription label: Time: ______________

Name of Medication(s): ____

**Please note: Any perscription to be administered must be provided in the original bottle with label, instructions, and dosage information.*

Describe the circumstances under which the medication is to be administered:

Dosage administered will be according to prescription label: Time: ______________

Parent/Legal Guardian Name ____

Signature of Parent/Legal Guardian ______________________ Date _____________

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