



# 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

- |  |   |
|--|---|
| <b>CALL<br/>911<br/>AND<br/>PARENT</b> | <ul style="list-style-type: none"> <li>• Stay calm and track the time (beginning and ending time of seizure)</li> <li>• Call another staff member to activate emergency response (911/calling parents)</li> <li>• Place individual on flat surface</li> <li>• Keep individual safe</li> <li>• Do NOT restrain</li> <li>• Do NOT place anything in individual's mouth</li> <li>• Roll individual to side (this will decrease risk of choking )</li> <li>• Stay with individual until EMS arrives</li> <li>• Staff member will accompany individual to medical facility until parents arrive</li> </ul> |
|--|---|

### Approving Signatures

I agree with the plan outlined above.

_____	_____
Parent/Guardian Printed Name and Signature	Date (YYYYMMDD)
_____	_____
Health Care Provider Signature <b>and Stamp</b> <u>(This signature serves as the exception to medication policy)</u>	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.