

4 Sample documentation

The following pages document sample care and support plans for three children:

Samantha

Natalie

Daniel



As well as the proformas used in this sample documentation, additional forms can be accessed from [A – Z Health Support Index > Forms](#) on the *chess* website: www.chess.sa.edu.au.

Seizure care plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client TYLER Samantha Date of birth 10.01.99
Family name (please print) First name (please print)

MedicAlert Number (if relevant) Nil Date for review 07.06.08

Description of this person's usual seizure activity

Warning signs (eg sensations)

None

Known triggers (eg illness, elevated temperature, flashing lights)

None known

Seizure Types	Further information about this person's seizures
Tick all those that apply. <input type="checkbox"/> Tonic clonic <input type="checkbox"/> Not responsive <input type="checkbox"/> Might fall down/cry out <input type="checkbox"/> Body becomes stiff (tonic) <input type="checkbox"/> Jerking of arms and legs occurs (clonic) <input type="checkbox"/> Excessive saliva <input type="checkbox"/> May be red or blue in the face <input type="checkbox"/> May lose control of bladder and/or bowel <input type="checkbox"/> Tongue may be bitten <input type="checkbox"/> Lasts 1-3 minutes, stops suddenly or gradually <input type="checkbox"/> Confusion and deep sleep (maybe hours) when in recovery phase. May have a headache.	Please indicate typical seizure frequency and length, and any management that is a variation from standard seizure management. Tonic clonic
<input checked="" type="checkbox"/> Absence <input checked="" type="checkbox"/> Vacant stare or eyes may blink/roll up <input type="checkbox"/> Lasts 5-10 seconds <input type="checkbox"/> Impaired awareness (may be seated) <input type="checkbox"/> Instant recovery, no memory of the event	Absence Seizure typically lasts 5-10 seconds.
<input type="checkbox"/> Simple partial <input type="checkbox"/> Staring, may blink rapidly <input type="checkbox"/> Only part of the brain is involved (partial) <input type="checkbox"/> Person remains conscious (simple), able to hear, may or may not be able to speak <input type="checkbox"/> Jerking of parts of the body may occur <input type="checkbox"/> Rapid recovery <input type="checkbox"/> Person may experience sensations that aren't real: <ul style="list-style-type: none"> ■ sounds ■ flashing lights ■ strange taste or smell ■ 'funny tummy' ■ or may just have a headache These are sometimes called an aura and may lead to other types of seizures.	Simple partial

Seizure Types	Further information about this person's seizures
Tick all those that apply.	Please indicate typical seizure frequency and length, and any management that is a variation from standard seizure management.
<input type="checkbox"/> Complex partial <input type="checkbox"/> Only part of the brain is involved (partial) <input type="checkbox"/> Person staring and unaware. Eyes may jerk but may talk, remain sitting or walk around <input type="checkbox"/> Toward the end of the seizure, person may perform unusual activities, eg chewing movement, fiddling with clothes (these are called automatisms) <input type="checkbox"/> Confused and drowsy after seizure settles, may sleep	Complex partial
<input type="checkbox"/> Myoclonic <input type="checkbox"/> Sudden simple jerk <input type="checkbox"/> May recur many times	Myoclonic

Recovery management

Signs that the seizure is starting to settle

Immediate recovery.

Duration (How long does recovery take if the seizure isn't long enough to require midazolam?)

Seconds.

Person's reaction

Samantha will remain motionless during the seizure but not fall, and not need any management other than observation until she recovers after a few seconds.

Any other recommendations to support the person during and after a seizure

May need prompting to resume activity and have instructions repeated.

Additional information attached to this care plan

- Medication authority
- Seizure management flow chart
- Observation/seizure log for completion by staff *(please specify how frequently this is requested)*

For one month review (07.06.07–07.07.07).

- General information about this person’s condition
- Other *(please specify)*

*This plan has been developed for the following services/settings:	
<input checked="" type="checkbox"/> School/education	<input checked="" type="checkbox"/> Outings/camps/holidays/aquatics
<input type="checkbox"/> Child/care	<input type="checkbox"/> Work
<input checked="" type="checkbox"/> Respite/accommodation	<input checked="" type="checkbox"/> Home
<input type="checkbox"/> Transport	<input type="checkbox"/> Other <i>(please specify)</i> _____
AUTHORISATION AND RELEASE	
Medical practitioner/epilepsy specialist <u>Dr Mark Lee</u>	Professional role <u>Neurologist</u>
Address <u>Southern Community Clinic</u>	
<u>South Road, Lonsdale SA 5160</u>	Telephone <u>8821 3111</u>
Signature <u>Mark Lee</u>	Date <u>07.06.07</u>
<i>I have read, understood and agreed with this plan and any attachments indicated above. I approve the release of this information to supervising staff and emergency medical personnel.</i>	
Parent/guardian or adult student/client <u>Tyler</u>	<u>Amber</u> Signature <u>A Tyler</u> Date <u>07.06.07</u>
<small>Family name (please print)</small>	<small>First name (please print)</small>

Health support plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the PRINCIPAL, DIRECTOR or HOME-BASED CARE PROVIDER, with the FAMILY and OTHERS as indicated below, for a child/student/client who requires individual health and personal care support in school, preschool or child care.

This plan should be based on written health care advice from a health professional.

It will involve risk assessment for staff in planning for the child/student/client.

This information is confidential and will be available only to supervising staff and emergency medical personnel.

Worksite name Adelaide Primary School

Name of child/student/client TYLER Samantha Date of birth 10.01.99
Family name (please print) First name (please print)

Date of this plan June 2007 Date for next review June 2008

Complex/invasive health support

Does the child/student/client have complex/invasive health care needs? Yes* No

(eg gastrostomy or other tube feeding, postural drainage, routine oxygen, tracheostomy care, catheter/stoma management)

*Refer to attached notes to assist in the completion of this Health support plan

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First aid

Is there any individual first aid requirement, other than basic first aid response? Yes* No

(eg in relation to asthma; anaphylaxis (including administration of prescribed adrenalin via an Epi-pen; administration of prescribed intranasal midazolam for seizure management; management of anxiety)

*Refer to attached notes to assist in the completion of this Health support plan

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.....

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Routine supervision for health care-related safety

Is there a known recommendation for additional supervision for health care-related safety? Yes* No

(eg a medication authority for administration during times when the child/student is in the care of staff; identified risk of self-harm or suicidal thoughts and behaviours; illness-related problems)

*Refer to attached notes to assist in the completion of this Health support plan

Safety watch for water activities eg aquatics, swimming.

Normal safety precautions for physical activity eg helmet for bike and horse riding.

Seizure log to be kept by class teacher (7.06.07–7.07.07): will tick and note times of any seizures (it is noted that the teacher may not notice all seizures).

Agreement

*This plan has been developed for the following services/settings:

- | | |
|--|---|
| <input checked="" type="checkbox"/> School/education | <input checked="" type="checkbox"/> Outings/camps/holidays/aquatics |
| <input type="checkbox"/> Child/care (including out of school hours care) | <input type="checkbox"/> Work |
| <input checked="" type="checkbox"/> Respite/accommodation | <input checked="" type="checkbox"/> Home |
| <input type="checkbox"/> Transport | <input type="checkbox"/> Other (please specify) _____ |

When will this child/student commence attending school/preschool or childcare?

If not immediately, detail actions and timelines to enable attendance, and any interim provisions

Already attending.

Principal/director
or care provider Smith Shane Signature S Smith Date 10.06.07
Family name (please print) First name (please print)

Staff/contact person
(if relevant) Simmons Dorothy Signature D Simmons Date 10.06.07
Family name (please print) First name (please print)

Who, apart from the family and those listed above, will have a copy of this plan?

1. _____ Role _____
Family name (please print) First name (please print)

Signature _____ Date _____

2. _____ Role _____
Family name (please print) First name (please print)

Signature _____ Date _____

3. _____ Role _____
Family name (please print) First name (please print)

Signature _____ Date _____

Authorisation

***I have read, understood and agreed with this plan and any attachments indicated above.
I support use of this plan by supervising staff.***

Parent/guardian
or adult student/client Tyler Meredith Signature M Tyler Date 10.06.07
Family name (please print) First name (please print)

Child/student Tyler Samantha Signature S Tyler Date 10.06.07
Family name (please print) First name (please print)

Seizure care plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client ATKINS Natalie Date of birth 16.10.98
Family name (please print) First name (please print)

MedicAlert Number (if relevant) Nil Date for review 07.06.08

Description of this person's usual seizure activity

Warning signs (*eg sensations*)

Known triggers (*eg illness, elevated temperature, flashing lights*)

Fatigue and stress

Seizure Types	Further information about this person's seizures
Tick all those that apply. <input type="checkbox"/> Tonic clonic <input type="checkbox"/> Not responsive <input type="checkbox"/> Might fall down/cry out <input type="checkbox"/> Body becomes stiff (tonic) <input type="checkbox"/> Jerking of arms and legs occurs (clonic) <input type="checkbox"/> Excessive saliva <input type="checkbox"/> May be red or blue in the face <input type="checkbox"/> May lose control of bladder and/or bowel <input type="checkbox"/> Tongue may be bitten <input type="checkbox"/> Lasts 1-3 minutes, stops suddenly or gradually <input type="checkbox"/> Confusion and deep sleep (maybe hours) when in recovery phase. May have a headache.	Please indicate typical seizure frequency and length, and any management that is a variation from standard seizure management. Tonic clonic
<input type="checkbox"/> Absence <input type="checkbox"/> Vacant stare or eyes may blink/roll up <input type="checkbox"/> Lasts 5-10 seconds <input type="checkbox"/> Impaired awareness (may be seated) <input type="checkbox"/> Instant recovery, no memory of the event	Absence
<input type="checkbox"/> Simple partial <input type="checkbox"/> Staring, may blink rapidly <input type="checkbox"/> Only part of the brain is involved (partial) <input type="checkbox"/> Person remains conscious (simple), able to hear, may or may not be able to speak <input type="checkbox"/> Jerking of parts of the body may occur <input type="checkbox"/> Rapid recovery <input type="checkbox"/> Person may experience sensations that aren't real: <ul style="list-style-type: none"> ■ sounds ■ flashing lights ■ strange taste or smell ■ 'funny tummy' ■ or may just have a headache <p>These are sometimes called an aura and may lead to other types of seizures.</p>	Simple partial

Seizure Types	Further information about this person's seizures
Tick all those that apply.	Please indicate typical seizure frequency and length, and any management that is a variation from standard seizure management.
<input checked="" type="checkbox"/> Complex partial <input type="checkbox"/> Only part of the brain is involved (partial) <input checked="" type="checkbox"/> Person staring and unaware. Eyes may jerk but may talk, remain sitting or walk around <input checked="" type="checkbox"/> Toward the end of the seizure, person may perform unusual activities, eg chewing movement, fiddling with clothes (these are called automatisms) <input checked="" type="checkbox"/> Confused and drowsy after seizure settles, may sleep	Complex partial Lip smacking and repetitive pulling of clothes. Seizure lasts 1-2 minutes. Typical recovery time is 30 seconds.
<input type="checkbox"/> Myoclonic <input type="checkbox"/> Sudden simple jerk <input type="checkbox"/> May recur many times	Myoclonic

Recovery management

Signs that the seizure is starting to settle

Jerking lessens. Eyes return to middle then close.

Duration *(How long does recovery take if the seizure isn't long enough to require midazolam?)*

Minutes.

Person's reaction

Natalie will be groggy and won't remember what happened.
Natalie prefers to sit at the back of the class, so her seizures are not noticed by her peers.

Any other recommendations to support the person during and after a seizure

Natalie will be confused and very tired after a seizure and may need to rest for up to half an hour.
Let Natalie know what has happened and reassure her that everything is okay.
Teachers need to be patient and responsive when Natalie asks for help to catch up.

Additional information attached to this care plan

- Medication authority
- Seizure management flow chart
- Observation/seizure log for completion by staff *(please specify how frequently this is requested)*

Record for one month if change in type of seizure and increased number.

- General information about this person's condition
- Other *(please specify)*

*This plan has been developed for the following services/settings:	
<input checked="" type="checkbox"/> School/education	<input checked="" type="checkbox"/> Outings/camps/holidays/aquatics
<input type="checkbox"/> Child/care	<input type="checkbox"/> Work
<input checked="" type="checkbox"/> Respite/accommodation	<input checked="" type="checkbox"/> Home
<input type="checkbox"/> Transport	<input type="checkbox"/> Other <i>(please specify)</i> _____
AUTHORISATION AND RELEASE	
Medical practitioner/epilepsy specialist <u>Anne Doyer</u>	Professional role <u>Neurologist</u>
Address <u>Women's & Children's Hospital</u>	
<u>72 King William Rd, North Adelaide SA 5006</u>	Telephone <u>8821 3111</u>
Signature <u>A Doyer</u>	Date <u>07.06.07</u>
<i>I have read, understood and agreed with this plan and any attachments indicated above.</i>	
<i>I approve the release of this information to supervising staff and emergency medical personnel.</i>	
Parent/guardian or adult student/client <u>Atkins</u>	Signature <u>C Atkins</u> Date <u>07.06.07</u>
<small>Family name (please print)</small>	<small>First name (please print)</small>

Health support plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the PRINCIPAL, DIRECTOR or HOME-BASED CARE PROVIDER, with the FAMILY and OTHERS as indicated below, for a child/student/client who requires individual health and personal care support in school, preschool or child care. This plan should be based on written health care advice from a health professional. It will involve risk assessment for staff in planning for the child/student/client. This information is confidential and will be available only to supervising staff and emergency medical personnel.

Worksite name Adelaide Primary School

Name of child/student/client ATKINS Natalie Date of birth 16.10.98
Family name (please print) First name (please print)

Date of this plan June 2007 Date for next review June 2008

Complex/invasive health support

Does the child/student/client have complex/invasive health care needs? Yes* No

(eg gastrostomy or other tube feeding, postural drainage, routine oxygen, tracheostomy care, catheter/stoma management)

*Refer to attached notes to assist in the completion of this Health support plan

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.....

.....

First aid

Is there any individual first aid requirement, other than basic first aid response? Yes* No

(eg in relation to asthma; anaphylaxis (including administration of prescribed adrenalin via an Epi-pen; administration of prescribed intranasal midazolam for seizure management; management of anxiety)

*Refer to attached notes to assist in the completion of this Health support plan

Deputy Principal to:

- ensure all staff access epilepsy and seizure first aid management
- update training from first aid training agency
- ensure all class teachers are aware of her triggers and typical seizure activity.

Natalie to be monitored by staff during seizure activity and provided with assistance if needed: Natalie would prefer her seizures to be managed quietly without too much attention being drawn to her situation.

Class Teachers to arrange for Natalie to have a quiet time following seizure activity if Natalie requests time to recover. Teachers need to be patient and responsive when Natalie asks for help to catch up with her work.

Routine supervision for health care-related safety

Is there a known recommendation for additional supervision for health care-related safety? **Yes*** **No**

(eg a medication authority for administration during times when the child/student is in the care of staff; identified risk of self-harm or suicidal thoughts and behaviours; illness-related problems)

*Refer to attached notes to assist in the completion of this Health support plan

Safety watch for water activities eg aquatics, swimming.
Normal safety precautions for physical activity eg helmet for bike and horse riding.

Personal care

Is there a need for additional support with daily living tasks? **Yes*** **No**

(eg assistance with personal hygiene (nose-blowing, handwashing, menstruation management), continence care, oral eating and drinking, transfers and positioning)

*Refer to attached notes to assist in the completion of this Health support plan

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Other considerations

Is there a need for additional support related to the wellbeing of the child/student? **Yes*** **No**

(eg related to psychological wellbeing; interrupted attendance; learning in other settings such as hospital and CAMHS programs; deteriorating health; grief and loss issues; palliative care)

*Refer to attached notes to assist in the completion of this Health support plan

Natalie, Dana and Josie are designated support peers. Dana and Josie have agreed to discreetly advise the nearest teacher if they think Natalie is having a seizure. Dana and Josie are support peers and are not able to be delegated duty of care or supervision responsibilities. Deputy principal to negotiate 'Caring with, for and about others' program for students in Natalie's year level during Term One. Any seizures will be recorded in the seizure observation log: family can ask for these to be copied for medical professionals. Natalie prefers to be seated at the back of the class, so her seizures are not noticed by her peers. Natalie's seizures may be triggered when she is tired or stressed. These triggers will need to be considered at times when Natalie is more at risk of these factors eg camp, exams.

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Agreement

*This plan has been developed for the following services/settings:

- | | |
|--|---|
| <input checked="" type="checkbox"/> School/education | <input checked="" type="checkbox"/> Outings/camps/holidays/aquatics |
| <input type="checkbox"/> Child/care (including out of school hours care) | <input type="checkbox"/> Work |
| <input checked="" type="checkbox"/> Respite/accommodation | <input checked="" type="checkbox"/> Home |
| <input type="checkbox"/> Transport | <input type="checkbox"/> Other (please specify) _____ |

When will this child/student commence attending school/preschool or childcare?

If not immediately, detail actions and timelines to enable attendance, and any interim provisions

Already attending

Principal/director
or care provider Clarke Sheila Signature S. Clarke Date 28.06.07
Family name (please print) First name (please print)

Staff/contact person
(if relevant) Mosel Peta Signature Peta Mosel Date 28.06.07
Family name (please print) First name (please print)

Who, apart from the family and those listed above, will have a copy of this plan?

1. _____ Role _____
Family name (please print) First name (please print)

Signature _____ Date _____

2. _____ Role _____
Family name (please print) First name (please print)

Signature _____ Date _____

3. _____ Role _____
Family name (please print) First name (please print)

Signature _____ Date _____

Authorisation

***I have read, understood and agreed with this plan and any attachments indicated above.
I support use of this plan by supervising staff.***

Parent/guardian
or adult student/client Atkins Margaret Signature M Atkins Date 28.06.07
Family name (please print) First name (please print)

Child/student Atkins Natalie Signature N Atkins Date 28.06.07
Family name (please print) First name (please print)

Seizure care plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client WALTERS Daniel Date of birth 08.02.93
Family name (please print) First name (please print)

MedicAlert Number (if relevant) 773 258 Date for review 07.06.08

Description of this person's usual seizure activity

Warning signs (eg sensations)

May complain of tummy being uncomfortable.

Known triggers (eg illness, elevated temperature, flashing lights)

Hot weather over 35°C. Sudden cooling or heating of the body. Illness.

Missed medication. Stress or over-excitement.

Seizure Types	Further information about this person's seizures
Tick all those that apply. <input checked="" type="checkbox"/> Tonic clonic <input checked="" type="checkbox"/> Not responsive <input checked="" type="checkbox"/> Might fall down/cry out <input checked="" type="checkbox"/> Body becomes stiff (tonic) <input checked="" type="checkbox"/> Jerking of arms and legs occurs (clonic) <input checked="" type="checkbox"/> Excessive saliva <input checked="" type="checkbox"/> May be red or blue in the face <input checked="" type="checkbox"/> May lose control of bladder and/or bowel <input checked="" type="checkbox"/> Tongue may be bitten <input checked="" type="checkbox"/> Lasts 1-3 minutes, stops suddenly or gradually <input checked="" type="checkbox"/> Confusion and deep sleep (maybe hours) when in recovery phase. May have a headache.	Please indicate typical seizure frequency and length, and any management that is a variation from standard seizure management. Tonic clonic <u>May complain of tummy being uncomfortable.</u> <u>If does not fall or slump to ground is not a tonic clonic.</u> <u>If seizure lasts more than 3 minutes give midazolam and call ambulance.</u>
<input type="checkbox"/> Absence <input type="checkbox"/> Vacant stare or eyes may blink/roll up <input type="checkbox"/> Lasts 5-10 seconds <input type="checkbox"/> Impaired awareness (may be seated) <input type="checkbox"/> Instant recovery, no memory of the event	Absence
<input type="checkbox"/> Simple partial <input type="checkbox"/> Staring, may blink rapidly <input type="checkbox"/> Only part of the brain is involved (partial) <input type="checkbox"/> Person remains conscious (simple), able to hear, may or may not be able to speak <input type="checkbox"/> Jerking of parts of the body may occur <input type="checkbox"/> Rapid recovery <input type="checkbox"/> Person may experience sensations that aren't real: <ul style="list-style-type: none"> ■ sounds ■ flashing lights ■ strange taste or smell ■ 'funny tummy' ■ or may just have a headache These are sometimes called an aura and may lead to other types of seizures.	Simple partial

Seizure Types	Further information about this person's seizures
Tick all those that apply.	Please indicate typical seizure frequency and length, and any management that is a variation from standard seizure management.
<input type="checkbox"/> Complex partial <input type="checkbox"/> Only part of the brain is involved (partial) <input type="checkbox"/> Person staring and unaware. Eyes may jerk but may talk, remain sitting or walk around <input type="checkbox"/> Toward the end of the seizure, person may perform unusual activities, eg chewing movement, fiddling with clothes (these are called automatisms) <input type="checkbox"/> Confused and drowsy after seizure settles, may sleep	Complex partial
<input type="checkbox"/> Myoclonic <input type="checkbox"/> Sudden simple jerk <input type="checkbox"/> May recur many times	Myoclonic

Recovery management

Signs that the seizure is starting to settle

Jerking lessens. Eyes return to middle then close.

Duration *(How long does recovery take if the seizure isn't long enough to require midazolam?)*

Minutes.

Person's reaction

Daniel will be groggy and won't remember what happened.
Daniel may worry about the reaction from other students.

Any other recommendations to support the person during and after a seizure

Daniel will be confused and very tired after a seizure and may need to rest for up to half an hour.
Let Daniel know what has happened and reassure him everything is okay.

Additional information attached to this care plan

- Medication authority
- Seizure management flow chart
- Observation/seizure log for completion by staff *(please specify how frequently this is requested)*

Record for one month if change in type of seizure and increased number.

- General information about this person's condition
- Other *(please specify)*

*This plan has been developed for the following services/settings:	
<input checked="" type="checkbox"/> School/education	<input checked="" type="checkbox"/> Outings/camps/holidays/aquatics
<input checked="" type="checkbox"/> Child/care	<input type="checkbox"/> Work
<input checked="" type="checkbox"/> Respite/accommodation	<input checked="" type="checkbox"/> Home
<input type="checkbox"/> Transport	<input type="checkbox"/> Other <i>(please specify)</i> _____
AUTHORISATION AND RELEASE	
Medical practitioner/epilepsy specialist <u>Dr John Michaels</u>	Professional role <u>Neurologist</u>
Address <u>3 Dorian Road, Adelaide SA 5000</u>	
	Telephone <u>8224 3333</u>
Signature <u>John Michaels</u>	Date <u>23.05.07</u>
<i>I have read, understood and agreed with this plan and any attachments indicated above. I approve the release of this information to supervising staff and emergency medical personnel.</i>	
Parent/guardian or adult student/client <u>Walters</u>	<u>Jenny</u> Signature <u>J Walters</u> Date <u>07.06.07</u>
<small>Family name (please print)</small>	<small>First name (please print)</small>

Intranasal midazolam (INM) authority

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the MEDICAL SPECIALIST and the PARENT/GUARDIAN/CLIENT/AUTHORISED PERSON.
This information is confidential and will be available only to persons trained to manage the person's seizures,
those providing training and emergency personnel.

Name of child/student/client WALTERS Daniel
Family name (please print) First name (please print)

Date of birth 08.02.93 Weight 28 kg

Allergies Nil

MedicAlert Number (if relevant) 773 258 Date for review 07.06.08

Call ambulance:

Immediately seizure begins

OR

For seizure lasting more than 3 minutes

Give intranasal midazolam:

Immediately seizure begins

OR

For seizure lasting more than 3 minutes

Dose of midazolam:

Use only plastic ampoule of 5mg in 1ml

Give all of one ampoule

OR

*This plan has been developed for the following services/settings:

School/education

Outings/camps/holidays/aquatics

Child/care

Work

Respite/accommodation

Home

Transport

Other (please specify) _____

AUTHORISATION BY NEUROLOGIST/PAEDIATRICIAN/SPECIALIST PHYSICIAN

Name of authorising practitioner Dr John Michaels

Address 3 Dorian Road, Adelaide SA 5000 Telephone 8224 3333

Signature John Michaels Date 23.05.07

This authorisation is valid for 12 months from the date signed by the authorised prescriber, unless otherwise advised.

EMERGENCY CONTACT DETAILS

Name of emergency contact Walters Jenny
Family name (please print) First name (please print)

Work telephone 8456 4567 Home telephone 8987 6543

Mobile telephone 0401 234 567 Relationship to person Mother

AUTHORISATION AND RELEASE

I have read, understood and agreed with this plan. I approve the release of this information to staff trained to manage seizures with intranasal midazolam, those providing training and emergency personnel.

Parent/guardian/client/authorised person Walters Jenny Signature J Walters Date 07.06.07
Family name (please print) First name (please print)

A copy of this form with original signatures will be held in the following locations:

First aid room. Front office reception.

Pre-requisites for safe first aid administration of intranasal midazolam (INM)

- The person administering intranasal midazolam requires knowledge of basic first aid and seizure management, and to be authorised to administer by their employer/agency/service.
- The person for whom INM is ordered must have had a previous dose of midazolam without adverse effect.
- Only a plastic ampoule containing 5mg in 1ml can be used.
- If midazolam is given in school, preschool or child/care, an ambulance must be called.
- Refer to the person's seizure care plan and seizure first aid plan.

Giving intranasal midazolam (INM)



1. Note time of onset of seizure
2. Check administration details on signed specialist authority
3. Check that the medication authority matches label on box
4. Check expiry date on ampoule
5. Check ampoule is 5mg in 1ml
6. Decide which side of person to work from (person's head to your left if you are right handed)
7. Turn person on back with head slightly extended, or position in wheelchair so head is back and airway open
8. Twist top off ampoule, and invert
9. Squeeze ampoule to drop out 1-3 drops into each nostril until ampoule empty. If movement marked, go more slowly 1 drop at a time to get into nose. Don't rush, first few drops should help slow seizure so other drops are easier to get in
10. As soon as practicable, turn person onto side in recovery position or support head in wheelchair, maintain clear airway
11. Note time seizure stops
12. Stay with the person; follow the standard first aid practice until ambulance arrives (follow person's Health Care Plan re calling ambulance)
13. Keep empty ampoule to give to ambulance officers
14. Nothing by mouth until the person starts conscious movements, as reduced gag reflex
15. Document.

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Worksite name Adelaide Primary School

Name of child/student/client WALTERS Daniel Date of birth 08.02.93
Family name (please print) First name (please print)

Date of this plan June 2007 Date for next review June 2008

Complex/invasive health support

Does the child/student/client have complex/invasive health care needs? Yes* No

(eg gastrostomy or other tube feeding, postural drainage, routine oxygen, tracheostomy care, catheter/stoma management)

*Refer to attached notes to assist in the completion of this Health support plan

First aid

Is there any individual first aid requirement, other than basic first aid response? Yes* No

(eg in relation to asthma; anaphylaxis (including administration of prescribed adrenalin via an Epi-pen; administration of prescribed intranasal midazolam for seizure management; management of anxiety)

*Refer to attached notes to assist in the completion of this Health support plan

If seizure lasts more than 3 minutes give midazolam and call ambulance
(keep empty ampoule to give to ambulance officers) Principal/Deputy to
meet ambulance at front gate.

Deputy Principal:
- Organise seizure first aid training for all staff
- Will ensure all class teachers are aware of his triggers and typical
seizure activity, and response required (as detailed in care plan).

Jan, Derek and Sue are identified to administer intranasal midazolam as/if
required.

INM is stored in thermal pack (provided by parents) in medication cabinet.
Alert cards are in yard duty bags and all classrooms: alert cards are sent to
front office immediately seizure activity occurs.

Parents notified by phone of all seizures by senior staff/delegate (also
recorded on observation and first aid log)

Routine supervision for health care-related safety

Is there a known recommendation for additional supervision for health care-related safety?

Yes* **No**

(eg a medication authority for administration during times when the child/student is in the care of staff; identified risk of self-harm or suicidal thoughts and behaviours; illness-related problems)

*Refer to attached notes to assist in the completion of this Health support plan

Daniel to access Resource Centre on hot days during breaks.....
All classrooms are air conditioned: if air conditioner is faulty.....
arrangements will be made to move class to a cooler location if needed.....
Bean bag in classroom for Daniel's seizure recovery (seizures less than 3.....
minutes): to go home if recovery takes longer than one hour.....
Bean bag is also for when he reports a 'funny tummy' (so he can be easily.....
rolled to recovery position if he seizures).....
Safety watch for water activities eg aquatics, swimming.....
Normal safety precautions for physical activity eg helmet for bike and.....
horse riding.....
Risk assessment prior to new physical activities, excursions and camps.....

Personal care

Is there a need for additional support with daily living tasks?

Yes* **No**

(eg assistance with personal hygiene (nose-blowing, handwashing, menstruation management), continence care, oral eating and drinking, transfers and positioning)

*Refer to attached notes to assist in the completion of this Health support plan

If Daniel wets/soils during a seizure and stays at school, one of the two.....
support staff working with his year level will ensure that Daniel is able to.....
manage changing his clothes (unless he prefers to go home to change).....
Staff will need to monitor Daniel. Spare clothes will be kept in the first.....
aid cupboard. Daniel's parents are happy to be contacted.....

Other considerations

Is there a need for additional support related to the wellbeing of the child/student?

Yes* **No**

(eg related to psychological wellbeing; interrupted attendance; learning in other settings such as hospital and CAMHS programs; deteriorating health; grief and loss issues; palliative care)

*Refer to attached notes to assist in the completion of this Health support plan

Relaxation program to be implemented in Daniel's class to support self-.....
monitoring of over excitement.....
Class teacher to inform Daniel's sister if Daniel has gone home or to.....
hospital.....
Copy of seizure observation log to be sent home as requested by the family.....
Use incident protocol if Daniel is taken to hospital (ie staff and student.....
debriefing).....
.....
.....

Epilepsy (and other health issues) awareness raising in health and physical education (Term 2) in all classes.

Daniel's seizures may be triggered when he is hot, stressed or over-excited. These triggers will need to be considered at times when Daniel is more at risk of these factors eg camps, excursions, outdoor activities in hot weather.

.....

.....

.....

Agreement

*This plan has been developed for the following services/settings:

- | | |
|--|---|
| <input checked="" type="checkbox"/> School/education | <input checked="" type="checkbox"/> Outings/camps/holidays/aquatics |
| <input type="checkbox"/> Child/care (including out of school hours care) | <input type="checkbox"/> Work |
| <input checked="" type="checkbox"/> Respite/accommodation | <input checked="" type="checkbox"/> Home |
| <input type="checkbox"/> Transport | <input type="checkbox"/> Other (please specify) _____ |

When will this child/student commence attending school/preschool or childcare?

If not immediately, detail actions and timelines to enable attendance, and any interim provisions

Already attending / Interim plan: call ambulance immediately until INM training provided for staff (planned 15/6/07).

Principal/director or care provider Kemp Mary Signature M Kemp Date 11.06.07
Family name (please print) First name (please print)

Staff/contact person (if relevant) Mason Julie Signature J Mason Date 11.06.07
Family name (please print) First name (please print)

Who, apart from the family and those listed above, will have a copy of this plan?

1. _____ Role _____
Family name (please print) First name (please print)
Signature _____ Date _____
2. _____ Role _____
Family name (please print) First name (please print)
Signature _____ Date _____
3. _____ Role _____
Family name (please print) First name (please print)
Signature _____ Date _____

Authorisation

I have read, understood and agreed with this plan and any attachments indicated above. I support use of this plan by supervising staff.

Parent/guardian or adult student/client Walters Peter Signature P Walters Date 11.06.07
Family name (please print) First name (please print)

Child/student Walters Daniel Signature D Walters Date 11.06.07
Family name (please print) First name (please print)

Seizure observation log

This form is designed to be used for general communication between families and staff to support child/student/client health and well-being. It can be used by families in consultations with health professionals to assist planning health and behaviour support for individual children/students/clients.

Name of child/student/client WALTERS Daniel 08.02.93
Family name (please print) First name (please print) Date of birth

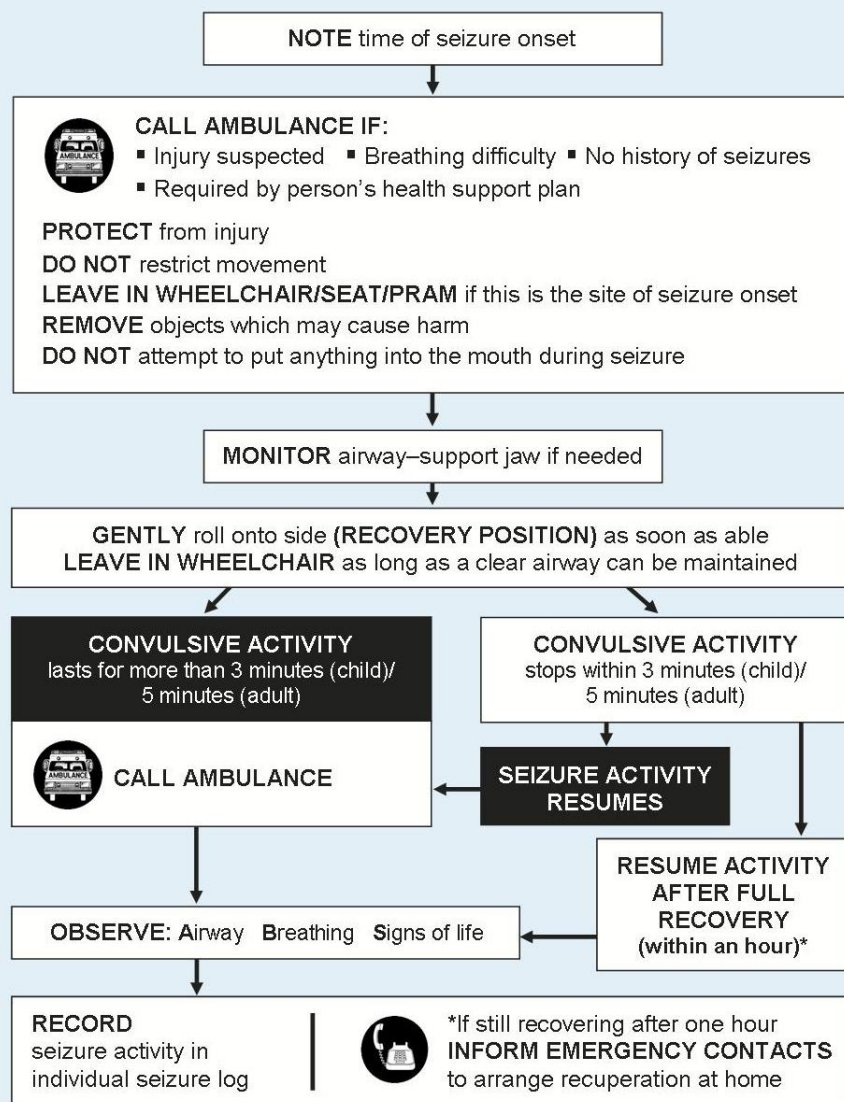
Date	Time	Length of seizure <small>(seconds or minutes)</small>	SEIZURE OBSERVATIONS* <small>(you can use the numbers below)</small>	RECOVERY OBSERVATIONS <small>(eg incontinence)</small>	Comments <small>(if any)</small>	Name <small>(printed and initialled) of person making entry</small>
14.06.07	11.20am	2 min	1, 8, 10	7	Recess time. On oval.	Jackie Allen JA
26.06.07	10.00am	5 min	1, 8, 10, 9	11	Ambulance called at 3 min. Midazolam given.	Debbie Lee DBL
04.07.07	2.00pm	2 min	1, 6, 10	3	During quiet class activity.	Debbie Lee DBL

*** Possible observations include:**

- 1. Sudden stare
- 2. Unresponsive to name
- 3. Prompt recovery (seconds)
- 4. Sudden onset nausea
- 5. Vision problems
- 6. Jerking of a limb
- 7. Gradual recovery (minutes)
- 8. Stiffening, convulsive activity
- 9. Laboured breathing
- 10. Unconsciousness
- 11. Slow recovery (confused and needing sleep)

A first aid guide for education and children's services

Seizure—major generalised



TO CALL AMBULANCE: Dial out, then 000 or mobile 112
 Say what state you are calling from, the person's condition and location



INFORM EMERGENCY CONTACTS in accordance with DECS guidelines

Department of Education and Children's Services SA with expert advice from Australian Red Cross SA Division and St John Ambulance Australia SA Inc, 2007 and The Epilepsy Centre SA



Additional first aid guide for a major generalised seizure (including use of intranasal midazolam) is available from [Pathways](#) on the *chess* website: www.chess.sa.edu.au. This seizure first aid flow chart indicates the point at which prescribed intranasal midazolam is given.

Health

-  **chess Training**
Health training, including first aid, health support planning and worksite health information modules (WHIMS)
-  **chess Research**
Details of the research partnerships
-  **chess A – Z Health Support Index**
Information and forms for health support planning. Care plans, resources and support related to conditions and care needs
-  **chess Education Services**
Hospital (and other health) education services
-  **chess Resource Materials**
child health and education support services resources and forms