SEIZURE ACTION PLAN

Effective Date__________

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name:______________________________ Date of Birth:______________

Parent/Guardian:______________________________ Phone: ______________

Treating Physician:______________________________ Phone: ______________

Significant medical history:____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:____

Student's reaction to seizure:____

BASIC FIRST AID: CARE & COMFORT: *(Please describe basic first aid procedures)*

Basic Seizure First Aid:
- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

Does student need to leave the classroom after a seizure? YES NO

If YES, describe process for returning student to classroom

OVER →

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- ☐ Contact school nurse at ______________________________
- ☐ Call 911 when ______________________________

for transport to ______________________________

- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other______________________________

A Seizure is generally considered an Emergency when:

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

TREATMENT PROTOCOL: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication	Dosage & When to Give	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use______________________________

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

Please include a description of any specific activity restrictions in the school environment.

Physician Signature:______________________________**Date:**____________

Parent Signature:______________________________**Date:**____________

Signed form indicates consent for physician staff and school staff to share information as needed to meet health needs of the student.

SCHOOL SEIZURE RECORD

Student's Name ______________________________ Date ______________

School ______________________ Grade _________ Teacher _____________

Parents' Names ________________________________ Phone (H) ________

(W) ________________________ and (W) ___________________________

Physician Treating Seizures _______________________ Phone ___________

1. Briefly describe your child's seizure:

2. Are there any warning symptoms that precede the seizure? If so, please explain.

3. Are there any particular circumstances that seem to cause seizures (ex. - fever)?

4. Date of child's last seizure:

5. Name the medications taken to control seizures, the dose, and how often taken:

6. Does your child suffer any side effects of these medication? (If so, list.)

7. Has the doctor put any restrictions on your child's activities?
   (Please attach doctor's note describing restrictions.)

SPECIAL PRECAUTIONS:

Signature of parent or guardian ________________________ Date _________