SEIZURE ACTION PLAN

Teachers/Grade ________________
Bus # _____

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: _____________Cell:________________

Treating Physician:_______________________________ Phone: _____________

Significant medical history:____

SEIZURE INFORMATION:

Seizure Type	*Average length*	*Description*

Average frequency:____

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 time of onset & duration

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

EMERGENCY RESPONSE:

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

____

____

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

- ☐ Contact school nurse
- ☐ Call 911 for transport to ____________________________________
- ☐ Notify parent or emergency contact
- ☐ Notify doctor if needed
- ☐ 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 a first-time seizure
- ✓ Student has breathing difficulties

TREATMENT PROTOCOL

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

***Emergency/Rescue Medication**

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Physician Signature

____

***See Medication Form**

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.)*

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Parent Signature:____**Date:**________________

CC: School Faculty (Principal, Assistant Principal, Secretary, Office Aide, Classroom/PE/Art/Music Teachers, Cafeteria Mgr, DARE Officer, Guidance Counselor, Librarian), School Health File, School Health Nurse, Bus Driver