



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: _____ Cell: _____
 Treating Physician: _____ Phone: _____
 Significant medical history: _____

SEIZURE INFORMATION:

| <i>Seizure Type</i> | <i>Length</i> | <i>Frequency</i> | <i>Description</i> |
|---------------------|---------------|------------------|--------------------|
| | | | |
| | | | |
| | | | |

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

BASIC FIRST AID: CARE & COMFORT:

(Please describe basic first aid procedures)

Does student need to leave the classroom after a seizure? YES NO
 If YES, describe process for returning student to classroom _____

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

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 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 DURING SCHOOL HOURS: (include daily and emergency medications)

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

Emergency/Rescue Medication _____

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.)*

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____