



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 _____

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| <p>Basic Seizure First Aid:</p> <ul style="list-style-type: none"> ✓ 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 <p><u>For tonic-clonic (grand mal) seizure:</u></p> <ul style="list-style-type: none"> ✓ Protect head ✓ Keep airway open/watch breathing ✓ Turn child on side |
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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 _____

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| <p>A Seizure is generally considered an Emergency when:</p> <ul style="list-style-type: none"> ✓ 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 |
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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: _____