



## **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 \_\_\_\_\_

### **EMERGENCY RESPONSE:**

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

#### **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

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: \_\_\_\_\_