



# 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:

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)

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: \_\_\_\_\_