

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 |
| Other Emergency Contact | Phone | Cell |
| Treating Physician | Phone | |
| Significant Medical History | | |

Seizure Information

| Seizure Type | Length | Frequency | Description |
|--------------|--------|-----------|-------------|
| | | | |
| | | | |
| | | | |

Seizure triggers or warning signs: _____ Student's response after a 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 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

Administer emergency medications as indicated below

Notify doctor

Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

| Emerg. Med. ✓ | Medication | Dosage & Time of Day Given | Common Side Effects & Special Instructions |
|---------------|------------|----------------------------|--|
| | | | |
| | | | |
| | | | |

Does student have a **Vagus Nerve Stimulator**? Yes No If YES, describe magnet use: _____

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ Date _____

Parent/Guardian Signature _____ Date _____