

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 reaction to seizure(s) _____

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
<input type="checkbox"/> Stay calm & track time <input type="checkbox"/> Keep child safe <input type="checkbox"/> Do not restrain <input type="checkbox"/> Do not put anything in mouth <input type="checkbox"/> Stay with child until fully conscious <input type="checkbox"/> Record seizure in log For tonic-clonic (grand mal) seizure: <input type="checkbox"/> Protect head <input type="checkbox"/> Keep airway open/watch breathing <input type="checkbox"/> 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)
<input type="checkbox"/> Contact school nurse at _____
<input type="checkbox"/> Call 911 for transport to _____
<input type="checkbox"/> Notify parent or emergency contact
<input type="checkbox"/> Administer emergency medications as indicated below
<input type="checkbox"/> Notify doctor
<input type="checkbox"/> Other _____

A seizure is generally considered an emergency when:
<input type="checkbox"/> Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
<input type="checkbox"/> Student has repeated seizures without regaining consciousness
<input type="checkbox"/> Student is injured or has diabetes
<input type="checkbox"/> Student has a first-time seizure
<input type="checkbox"/> Student has breathing difficulties
<input type="checkbox"/> 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.)

 Physician Signature _____ Date _____
 Parent/Guardian Signature _____ Date _____