

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 AND COMFORT
 (Please describe basic first aid procedures)

- Basic Seizure First Aid:**
- Stay calm and 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:

- A seizure is generally considered an emergency when:
- A convulsion (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

Seizure Emergency Protocol: (check all that apply and clarify below)

___ Call 911 for transport to _____

___ Notify parent or emergency contact

___ Notify doctor

___ Administer emergency medications as indicated below

___ Other _____

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 AND SAFETY PRECAUTIONS (regarding school activities, sports, trips, etc.)

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____