SEIZURE ACTION PLAN

School ______________________________ Fax Number_______________________ Effective Dates_____________________

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF SEIZURE OCCURS DURING SCHOOL HOURS. THIS INFORMATION IS CONFIDENTIAL.

Student's Name:____Date of Birth:______________________________

Parent/Guardian:____ Phone: _________________________

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)*

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:

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 ____

Basic Seizure First Aid:

- ✔ 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

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 and 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)

1. As parent/guardian of _______________, I give permission for this plan to be available for use in my child's school, and for the nurse consultant to contact the above named physician by phone, fax or in writing when necessary to complete this plan.
2. It is understood by parents and physicians that this plan may be carried out by school personnel other than the school nurse. The school's registered nurse is responsible for delegation of this plan to unlicensed school personnel when appropriate.
3. This plan will be reviewed annually and/or whenever the health status or medications change and it is the responsibility of the parent to notify the school nurse of these changes.

Physician signature: ____ **Date:** ______________________

Parent Signature: ____ **Date:** ______________________

School Nurse Signature: ____________________________________ **Date:** ______________________