Every child. Every day.
Mooresville
GRADED SCHOOL DISTRICT

SEIZURE EMERGENCY ACTION PLAN

NAME: _____ Date of Birth: _____

School: _____ Grade: _____ Homeroom Teacher: _____

Contact Information:
Parent/Guardian: _____ Telephone # (w) _____
Address: _____ Telephone # (h) _____
Emergency Contact: _____ Telephone # _____

Physician Treating Student for Seizures: _____ Telephone # _____
Other Physician: _____ Telephone # _____

EMERGENCY PLAN (Fill in blanks, cross out and initial any steps not needed for this student.)

Emergency action is necessary when the student has the following symptoms:

_____

Steps to take during a seizure:

1. **Notify the School Nurse or First Responder.**
2. **Stay with the student during and after a seizure. Note the duration and type of body movement during the seizure episode.**
3. **Assist the student to a lying position if loss of consciousness occurs. Please remove any glasses that the student is wearing and loosen clothing around the neck.**
4. **Turn the student on the side as soon as possible.**
5. **Clear the area around the student to prevent injury, and remove other students from the area.**
6. **DO NOT RESTRAIN MOVEMENT OF PLACE ANYTHING IN THE STUDENT'S MOUTH.**
7. **Monitor breathing and notify the First Responder to begin artificial respirations if breathing does not resume spontaneously.**
8. **Call 911 if seizure lasts longer than 5 minutes, the student has one seizure after another without waking, or there are signs of significant injury or physical/respiratory distress. If 911 is called, transport to _____ Hospital.**
9. **When the seizure is over, allow the student to rest and always notify the parent/guardian.**
10. **Other instructions for this student: _____**

See reverse side for more instructions

Seizure Daily Management Plan

1. **What type of seizures does this student have and how often do they occur?**

   _____

2. **Date of last seizure: _____**

3. **Describe this student's symptoms during and after a seizure episode. _____**

   _____

4. **Does this student have an aura or warning of a seizure coming? Yes _____ No _____ Is this student able to notify anyone that a seizure is coming? Yes _____ No _____**

5. **Daily medication:**

   Name of medication: _____ Dosage: _____ Time(s) of day: _____

   Name of medication: _____ Dosage: _____ Time(s) of day: _____

   Name of medication: _____ Dosage: _____ Time(s) of day: _____

6. **Side effects of these medications this student may experience include: _____**

   _____

7. **This student CAN NOT participate in the following activities:**

   _____

8. **This student wears a "Medic Alert": Yes _____ No _____**

Please note: If medications are to be taken at school, a Medication Authorization form must be completed by a parent/guardian and a physician.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Review Date: _____

THIS INFORMATION WILL BE SHARED WITH APPROPRIATE SCHOOL STAFF UNLESS OTHERWISE STATED.