EPILEPSY FOUNDATION® MINNESOTA
Not another moment lost to seizures™

YOUTH Seizure Action Plan & Parent Questionnaire

THIS INDIVIDUAL IS BEING TREATED FOR A SEIZURE DISORDER. INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS.

Nurse's Name: _____ Phone: _____

Student's Name: _____ School Year: _____

School: _____ Grade: _____ Classroom: _____

Parent/Guardian Name: _____ Tel. (H): _____ (W): _____ (C): _____

Other Emergency Contact: _____ Tel. (H): _____ (W): _____ (C): _____

Child's Neurologist: _____ Tel: _____ Location: _____

Child's Primary Care Dr.: _____ Tel: _____ Location: _____

Significant medical history or conditions: _____

SEIZURE INFORMATION:

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Response after a seizure: _____

TREATMENT PROTOCOL: (include daily and emergency medications)

Emergency Med? √	*Medication*	*Dosage & Time Given*	*Route of Administration*	*Common Side Effects & Special Instructions*

Does child have a **Vagus Nerve Stimulator (VNS)?** ❑ YES ❑ NO

If YES, describe magnet use _____

BASIC FIRST AID: CARE & COMFORT:

Please describe basic first aid procedures: _____

_____

Does person need to leave the room/area after a seizure? ❑ YES ❑ NO

If YES, describe process for returning: _____

_____

EMERGENCY RESPONSE:

A "seizure emergency" for this person is defined as: _____

_____

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

Basic seizure first aid:
- Stay calm & track time
- Keep person safe
- Do not restrain
- Do not put anything in mouth
- Stay with person until fully conscious
- Record seizure in log

For tonic-clonic (grand mal) seizure:
- Protect head
- Keep airway open/watch breathing, color
- Turn person on side

A seizure is considered an emergency when:
- A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- There are repeated seizures without regaining consciousness
- It's a first-time seizure
- The person is injured or has diabetes
- The person has breathing difficulties
- The seizure is in water

YOUTH Seizure Action Plan & Parent Questionnaire

SEIZURE INFORMATION:

1. When was your child diagnosed with epilepsy?

2. Will your child need to leave the classroom after a seizure? ❑ YES ❑ NO

   If YES, describe best process for returning your child to classroom:_____

3. How often does your child have a seizure? _____

4. When was your child's last seizure? _____

5. Has there been any recent change in your child's seizure patterns? ❑ YES ❑ NO

   If YES, please explain: _____

6. How do other illnesses affect your child's seizure control? _____

7. What medication(s) will your child need to take during school hours? _____

8. Should any of these medications be administered in a special way? ❑ YES ❑ NO

   If YES, please explain: _____

9. Should any particular reaction be watched for? ❑ YES ❑ NO

   If YES, please explain: _____

10. What should be done when your child misses a dose?_____

11. Should the school have backup medication available to give your child for missed dose? ❑ YES ❑ NO

12. Do you wish to be called before backup medication is given for a missed dose? ❑ YES ❑ NO

SPECIAL CONSIDERATIONS & PRECAUTIONS

Check any special considerations related to your child's epilepsy while at school.
(Check appropriate boxes and describe the impact of your child's seizures or treatment regimen)

❑ General health:

❑ Physical functioning:

❑ Learning:

❑ Behavior:

❑ Mood/coping:

❑ Other:_____

❑ Physical education (gym)/sports:

❑ Recess:

❑ Field trips:

❑ Bus transportation:

GENERAL COMMUNICATION ISSUES

What is the best way for us to communicate about your child's seizure(s)?: _____

Does your child have permission to contact your child's physician? ❑ YES ❑ NO

Can this information be shared with classroom teacher(s) and other appropriate school personnel? ❑ YES ❑ NO

Physician Signature: _____ Date:_____

Dates Updated _____, _____

Physician Signature: _____ Date:_____