OSSEO AREA SCHOOLS
ISD 279

student's photo

Osseo Area Schools: SEIZURE ACTION PLAN

School Year:

Student's Name: ___ Date of Birth:
Student's Address:
School Name: ___ School Address: ___ Grade:
Parent/Guardian: ___ Phone: ___ Cell:
Parent/Guardian: ___ Phone: ___ Cell:
Treating Physician: ___ Phone: ___
Significant medical history: ___

TYPES OF SEIZURES:

☐Absence - staring and decrease in responsiveness ☐Simple partial seizures ☐Complex partial seizures

☐Generalized tonic-clonic seizures ☐Tonic seizures ☐Drop (atonic) seizures ☐Other (Specify)

Seizure symptoms/triggers/ warning signs/ last seizure:

SEIZURE INFORMATION:

- Date of last seizure:
- Describe typical seizure:
- Length of typical seizure:
- Frequency of seizures: ☐Daily ☐Weekly ☐Monthly ☐ Other (Specify)
- Possible triggers:
- Student's response after seizure:

BASIC FIRST AID: CARE & COMFORT:

1. Note time the seizure begins and ends.
2. Remove objects around student such as chairs, desks, or tables to provide a safe environment.
3. Loosen tight clothing and turn student on side, if able.
4. Do not restrain student. Do not attempt to put anything in student's mouth.
5. Assure student that everything is all right. Stay with student until fully recovered. Allow student to rest after seizure.
6. Document how long seizure lasted and report to parents or emergency personnel, as needed.

EMERGENCY RESPONSE: Contact building nurse at:

A "seizure emergency" for this student is defined as: (please complete)

Seizure Emergency Protocol:

- Administer emergency medications as indicated below, for seizures lasting greater than ___ minutes.
- Call 911 when emergency medications administered or if student is having difficulty breathing.
- Notify parent or emergency contact.

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Medication	Dosage/Route	Special Instructions

Medication taken at home on a daily basis:

Does student have a **Vagus Nerve Stimulator (VNS)**? ☐ YES (If VNS see attached info) ☐ NO

TYPES OF LIMITATIONS:

☐No Limitations ☐Playground (specify):

☐Physical Education (specify): ☐Other (specify):

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: (regarding school activities, sports, trips, etc.)

Nurse Signature: ___ **Date:**

Parent Signature: _____ **Date:** _____

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