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 _____

Other Emergency Contact _____ 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(s) _____

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
❏ Administer emergency medications as indicated below
❏ Notify doctor
❏ Other_____

TREATMENT PROTOCFOL DURING SCHOOL HOURS (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator**?   ❏YES   ❏NO   If YES, describe magnet use

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

_____

Physician Signature_____ Date_____

Parent/Guardian Signature_____ Date_____