San Angelo Independent School District
Health Services
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:_____

Treating Physician:_____ Phone: _____

Significant medical history:_____

SEIZURE INFORMATION:

Seizure Type	*Average length*	*Description*

Average frequency:_____

Seizure triggers or warning signs:_____

Student's reaction to seizure:_____

BASIC FIRST AID: CARE & COMFORT: *(Please describe basic first aid procedures)*

Basic Seizure First Aid:
- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Turn child on side
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log
- ✓ Expect to see pale/bluish discoloration of skin or lips.

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing

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_____

A Seizure is generally considered an Emergency and you should CALL 911 when:
- ✓ A 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

TREATMENT PROTOCOL DURING SCHOOL HOURS:

Daily Medication | Dosage & 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.)*

Physician Signature:_____ **Date:**_____

Parent Signature:_____ **Date:**_____