EPILEPSY FOUNDATION
Minnesota

Youth Seizure Action Plan

CONTACT INFORMATION:

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)

Medication	*Emergency Med?*	*Dosage & Time of Day 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: _____

_____

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
- Turn person on side

EPILEPSY FOUNDATION
Minnesota

Youth Seizure Action Plan

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_____

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

SEIZURE INFORMATION:

1. When was your child diagnosed with epilepsy?_____
2. How often does your child have a seizure?_____
3. Has there been any recent change in your child's seizure patterns? YES NO
   If YES, please explain:_____
4. How do other illnesses affect your child's seizure control?_____
5. What should be done when your child misses a dose?_____
   (Refer to physician care plan)

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 school personnel 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

Parent Signature:_____Date:_____ Dates Updated _____, _____

Physician Signature:_____Date:_____

Once this Seizure Action Plan has been filled out, take a copy for the school nurse to keep.

Visit EFMN.ORG for additional resources.