EPILEPSY FOUNDATION®
Not another moment lost to seizures

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 response after a seizure:

Basic First Aid: Care & 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:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

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 _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol 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 Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

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FOOD/INSECT & EMERGENCY ALLERGY CARE PLAN and MEDICATION AUTHORIZATION

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician's assistant, and for interscholastic and intramural sports only, a podiatrist) and parent/guardian written authorization, for the nurse, or in the absence of the nurse, a qualified school personnel to administer medication.

STUDENT INFORMATION

Student Name	**DOB:**
Home/Cell Phone	**Grade**
Known Life-Threatening Allergies:	**History of Asthma?** ☐ No ☐ Yes **(Asthma may indicate an increased risk of severe reaction)**
Diagnosis of Oral Allergy Syndrome? ☐ No ☐ Yes **Please list OAS allergens:**	**History of SEVERE Anaphylactic Reaction?** ☐ No ☐ Yes, If checked YES, give epinephrine immediately if allergen was ***likely*** eaten, at onset of ***any*** symptoms, and follow the protocol below

TREATMENT PLAN

ANY ONE OF THESE SEVERE SYMPTOMS OF ANAPHYLAXIS AFTER SUSPECTED OR KNOWN INGESTION:

- **Difficulty breathing or swallowing**
- **Dizzy, faint, confused, pale or blue, hypotension/weak pulse**

OR

ANY COMBINATION OF SYMPTOMS FROM DIFFERENT BODY AREAS:

AIRWAY: Short of breath, chest tightness, wheeze, repetitive cough, profuse runny nose
THROAT: Tight, hoarse, trouble breathing/swallowing, drooling
MOUTH: Swollen lips or tongue
SKIN: Hives, Itchy rashes, swelling (e.g., eyes, lips)
GUT: Nausea, Vomiting, diarrhea, crampy pain

FOLLOW THIS PROTOCOL:

1. **INJECT EPINEPHRINE IMMEDIATELY!**
2. Call 911
3. Raise feet above the head, remain lying down & continue monitoring
4. Give additional medications as ordered
   - Antihistamine
   - Bronchodilator/Albuterol if has asthma
5. Notify Parent/Guardian
6. Notify Prescribing Provider / PCP
7. When indicated, assist student to rise slowly.

ORAL ALLERGY SYNDROME (IF DIAGNOSIS CONFIRMED ABOVE):

MOUTH: Itchy mouth, lips, tongue and/or throat
SKIN: Itching just around mouth

1. **GIVE ANTIHISTAMINE** (swish, gargle, &swallow)
2. Monitor student as indicated; notify healthcare provider & parent as indicated
3. If progresses to symptoms of anaphylaxis, USE EPINEPHRINE (as stated above)

➢ **THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL SYMPTOMS OF ANAPHYLAXIS CAN POTENTIALLY PROGRESS TO A LIFE THREATENING SITUATION!!**

DOSAGE OF MEDICATIONS

Epinephrine	☐ Epi Auto-injector, Jr (0.15mg) inject intramuscularly ☐ Epi Auto-injector (0.3mg) inject intramuscularly ➢ A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur.		
Antihistamine	☐Benadryl/Diphenhydramine Dose: Route: PO Frequency:	☐Other Dose: Route:	**Relevant Side Effects** ☐ Tachycardia ☐Other
Medication shall be administered during school year:	TO	**NOTE: IF NURSE IS NOT AVAILABLE, THE EPINEPHRINE AUTO INJECTOR MAY BE GIVEN BY DESIGNATED SCHOOL PERSONNEL FOR ANY ANAPHYLAXIS SYMPTOMS**	

TO BE COMPLETED BY PARENT AND AUTHORIZED HEALTHCARE PROVIDER

AUTHORIZATION

Prescriber's Signature: **Prescriber's Authorization to Self Administer** *Confirms student is capable to safely and properly administer medication* ☐ Yes ☐ No	**Date:** **PRESCRIBER'S PRINTED NAME OR STAMP**
Parent: I hereby request that the above ordered medication be administered by school personnel and consent to communications between the school nurse and the prescriber that are necessary to ensure safe administration of this medication. This protocol will be in effect until the end of the current or extended school year. This medication will be destroyed if not picked up within one week following termination of the order or the end of the school year. Whichever comes first, unless the student will be attending an extended school year (ESY) program. A new protocol will be needed for the next school year. I have received, reviewed and understand the above information.	
Parent's Signature: **Parent's Authorization to Self Administer** ☐ Yes ☐ No	**Date:**