



# YOUTH Seizure Action Plan & Parent Questionnaire

THIS INDIVIDUAL IS BEING TREATED FOR A SEIZURE DISORDER. INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS.

Nurse's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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 Type	Length	Frequency	Description

Seizure triggers or warning signs: \_\_\_\_\_

Response after a seizure: \_\_\_\_\_

**TREATMENT PROTOCOL: (include daily and emergency medications)**

Emergency Med?  Medication      Dosage & Time Given      Route of Administration      Common Side Effects & Special Instructions

Emergency Med? <input type="checkbox"/>	Medication	Dosage & Time 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: \_\_\_\_\_

\_\_\_\_\_

**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

**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, color
- Turn person on side

**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

  


## YOUTH Seizure Action Plan & Parent Questionnaire

### SEIZURE INFORMATION:

1. When was your child diagnosed with epilepsy? \_\_\_\_\_

2. Will your child need to leave the classroom after a seizure?  YES  NO

If YES, describe best process for returning your child to classroom: \_\_\_\_\_

3. How often does your child have a seizure? \_\_\_\_\_

4. When was your child's last seizure? \_\_\_\_\_

5. Has there been any recent change in your child's seizure patterns?  YES  NO

If YES, please explain: \_\_\_\_\_

6. How do other illnesses affect your child's seizure control? \_\_\_\_\_

7. What medication(s) will your child need to take during school hours? \_\_\_\_\_

8. Should any of these medications be administered in a special way?  YES  NO

If YES, please explain: \_\_\_\_\_

9. Should any particular reaction be watched for?  YES  NO

If YES, please explain: \_\_\_\_\_

10. What should be done when your child misses a dose? \_\_\_\_\_

11. Should the school have backup medication available to give your child for missed dose?  YES  NO

12. Do you wish to be called before backup medication is given for a missed dose?  YES  NO

### 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 education (gym)/sports:

Physical functioning:

Recess:

Learning:

Field trips:

Behavior:

Bus transportation:

Mood/coping:

Other: \_\_\_\_\_

### GENERAL COMMUNICATION ISSUES

What is the best way for us to communicate about your child's seizure(s)? \_\_\_\_\_

Does your child 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

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dates Updated \_\_\_\_\_, \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_