Seizure Action Plan

Effective Dates _____

This student is being treated for a seizure disorder. The information below should assist you if a seizure or any suspected seizure-like activity occurs during school hours.

Student's Name	Date of Birth	
Parent/Guardian	Phone	Cell
Other Emergency Contact	Phone	Cell
Treating Physician	Phone	

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 campus after a seizure? ☐ Yes ☐ No

Does parent/guardian need to be contacted after any suspected seizure activity, regardless of duration? ☐ Yes ☐ No

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 _____

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

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 Consent for Management of Health Condition at School

I, the parent or guardian of the above named student, request that this School Health Care Plan be used to guide care for my child during school hours. I agree to:

1. Provide necessary supplies and equipment.
2. Notify the school nurse of any changes in the student's health status.
3. Notify the school nurse and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school nurse to communicate with the primary care provider/specialist about this health condition, including signing a separate Authorization for Release of Information form as needed.
5. Consent that school staff interacting directly with my child may be informed about his/her special needs while at school and receive a copy of this care plan and instruction from the school nurse about it.

Submit medication authorization forms if student is to have medication administered at school.

Parent/Guardian Signature _____ **Date** _____