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** _____

DPC772

RANDOLPH TOWNSHIP SCHOOLS
RANDOLPH, NEW JERSEY

Parent Authorization for Medication to be Taken During School Hours

Student's Name _____ Sex _____ Date of Birth _____

School _____ Teacher _____ Grade _____ Room _____

Physician's Name Address Telephone

_____

_____

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons.

_____ _____
Parent/Guardian Signature Date

_____ _____ _____
Parent/Guardian's Name (please print) Home Phone Emergency Phone

Physician Authorization for Medications to be Taken During School Hours

TYPE OF ILLNESS: _____

MEDICATION/DOSAGE: _____

TIMES TO BE ADMINISTERED: _____

If medication is "when needed", describe indications:

_____

_____

HOW SOON CAN DOSAGE BE REPEATED? _____

POSSIBLE SIDE EFFECTS: _____

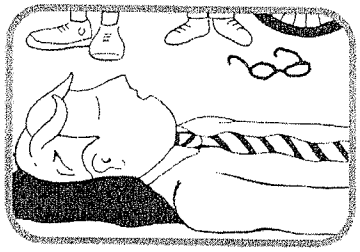
LENGTH OF TIME MEDICATION IS TO BE CONTINUED: _____

_____ _____
Physician's Signature Date

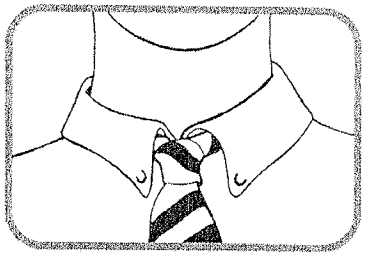
_____
Physician's Name (please print)

First Aid for Seizures

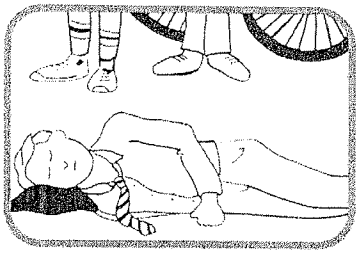
(Convulsions, generalized tonic-clonic, grand mal)



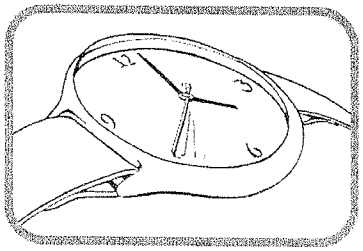
Cushion head, remove glasses



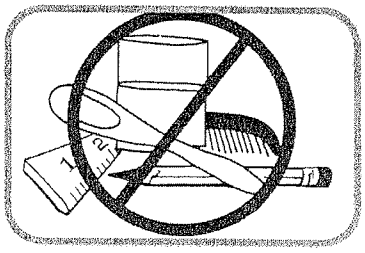
Loosen tight clothing



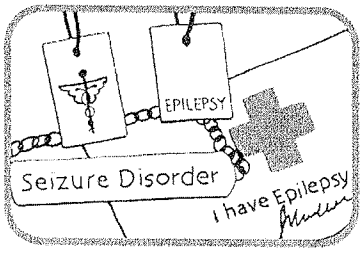
Turn on side



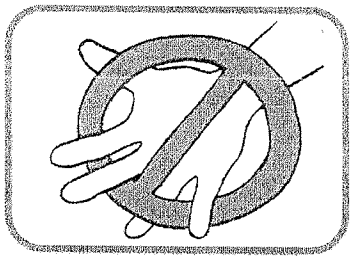
Time the seizure with a watch



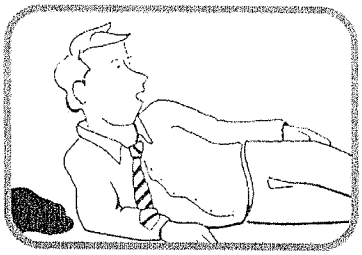
Don't put anything in mouth



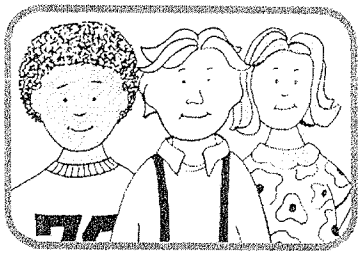
Look for I.D.



Don't hold down



As seizure ends...



...offer help