

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 _____

Edina Public Schools Seizure Action Plan
(This page to be completed by parent/guardian)

Student's Name: _____ School: _____

School Year: _____

Parent/Guardian Authorization

1. I agree with the above Seizure Action Plan and I request that the above medication/s be given during school hours as ordered by my child's physician/licensed prescriber.
2. I request that the above medication be sent on field trips. Yes No
3. I will notify the school if medication is stopped.
4. I give permission for the medication/s to be given by school personnel as delegated, trained, and supervised by the licensed school nurse.
5. Legally I may refuse to sign the Seizure Action Plan. If I refuse to sign, the district will not be able to administer the prescribed medication.
6. This consent may be revoked at any time by sending a written notice to the licensed school nurse.

Parent/Guardian Signature

Date

Permission for Release of Information

1. I give permission for the school nurse to communicate, as needed with school staff about my child's medical condition/s and the action of the medication/s.
2. I give permission for the licensed school nurse to contact my child's physician/licensed prescriber regarding questions about the above listed medication/s or medical condition/s being treated by medication/s. If I do not give permission, the district may not be able to administer medication.

Parent/Guardian Signature

Date

Licensed School Nurse _____ Date _____

Health Associate _____ Date _____

For Licensed School Nurse Use

Trained personnel delegated to administer Diastat

1. _____ Date: _____
2. _____ Date: _____