Western Heights
PUBLIC SCHOOLS

Seizure Action Plan

Effective Date: _____

Student's Name: _____
DOB: _____ Grade: _____ Age: _____
Parent/ Guardian: _____
Treating physician: _____ Phone # _____

Contact phone numbers: (Please list in the order in which calls should be made. Also note if each person has legal authority to respond in an emergency situation.)

Number	Name, Relationship	Authority?

Allergies (food, medication, etc) _____

Seizure information:

At what age was your child diagnosed with seizures or epilepsy? _____
When was your child's last seizure? _____

Seizure type	Length	Frequency	Description

Seizure triggers or warning signs: _____
Student's reaction to seizure: _____
How do illnesses affect your child's seizure control? _____
Has there been any recent change in your child's seizure pattern? _____
Has your child ever been hospitalized for a seizure? YES NO If yes, when? _____
Activity restrictions:_____
Safety precautions: _____

Basic First Aid: Care and Comfort:

(Please describe basic first aid procedures)

_____

_____

Does the student need to leave the classroom after a seizure? YES NO

If yes, describe the process for returning student to classroom.

_____

Basic Seizure First Aid:

- ✓ Stay calm and 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 (grand mal) seizure:

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

Emergency Response:

A "seizure emergency" for your 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
- ☐ Notify doctor
- ☐ Other _____

A seizure is generally considered an emergency when:

- ✓ A convulsive seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

Medications student routinely takes

Daily Medication	Dosage and time of day given	Common Side effects & Special Instructions

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

You will be notified before giving backup medications.

Does the student have **Vagus Nerve Stimulation (VNS)?** YES NO

If yes, describe magnet use _____

What is the best way to contact you if we have any questions? _____

I/We the undersigned parent(s)/guardian of _____, hereby request the school nurse or designee to administer the above procedure according to physician's instructions. We agree to notify the school nurse immediately if there is any change in the student's status or physician's orders. I also consent to the release of the information contained in this seizure care plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also consent to the school nurse and/or necessary staff members to contact my child's physician regarding their seizure disorder. We also understand that if 911 is called, our child will be transported to a medical facility or will be taken home for the remainder of the school day.

Parent Signature _____Date_____

**This form must be updated at least yearly at the beginning of the school year or sooner if condition indicates. 05/10