Seizure Action Plan

School Phone # _____
School Fax # _____

This student is being treated for a seizure disorder. The information below may assist if a seizure occurs during school hours or at school activities.

Student Name: _____ **Date of Birth:** _____ **School:** _____
Parent/Guardian: _____ **Home Phone:** _____ **Cellular:** _____
Primary Physician: _____ **Phone:** _____ **FAX:** _____
Neurologist: _____ **Phone:** _____ **FAX:** _____

Physician completes form from this point forward.

Significant Medical History: _____

Seizure Information

Seizure Type	Length	Frequency	Description	Last Seizure Date

Seizure triggers or warning signs: _____

Student's response after seizure: _____

Seizure Response – BASIC

- Stay calm and record start of seizure
- Keep child safe but Do NOT restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Document ending time and description of seizure

Tonic-clonic seizure additional response: • Protect child's head • Turn child on side • Keep airway open • Monitor breathing

Additional Individual Student Information:

Parent requests notification after each seizure ☐ Yes ☐ No
Does student need to leave the classroom after a seizure? ☐ Yes ☐ No
If YES, describe process for returning student to classroom: _____

In case of incontinence, parent should provide extra clothing for school so student may return to class as allowed by process above. ☐ Yes ☐ No

Seizure Response – EMERGENCY

☐ Call 911 for paramedics
☐ Contact school nurse
☐ Administer emergency medications if indicated below
☐ Notify parents or emergency contact (as listed above)
☐ Notify doctor listed above
☐ 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, has diabetes, or is pregnant
Student has a first-time seizure
Student has breathing difficulties
Student has a seizure in water

A "seizure emergency" for this student is additionally defined as: _____

Treatment Protocol During School Hours or School Activities (include daily and emergency medications*)

* Emergency Medication?	*Medication Name	Dosage and Time of Day Given	Common Side Effects and Special Instructions
☐ Y or ☐ N			
☐ Y or ☐ N			

Does student have a Vagus Nerve Stimulator? ☐ Yes ☐ No, If YES, describe magnet use: _____
Call 911 if still seizing after _____ VNS swipes. Wait _____ minutes between swipes. Give _____ swipes before any emergency medication.

Special Considerations and Precautions (regarding school activities, sports, trips, helmet use, or bus riding after seizure, etc.)

Describe any special considerations or precautions: _____

Physician Name: _____ ***Physician Signature:*** _____ ***Date:*** _____

I give permission for school staff to contact the physician for consultation and exchange of information as needed.

Signature of Parent or Guardian: _____ ***Date:*** _____ **Phone Number:** _____

This form must be renewed annually or with any change in treatment or medication.

The *Medication Administration Form* must be completed in addition to the *Seizure Action Plan* if medication is required at school or school activities.

* Medication Administration Form Required