ST. MARY'S COUNTY PUBLIC SCHOOLS

Department of Student Services

EMERGENCY ACTION PLAN

SEIZURES

Student Name:	DOB:	Date Initiated:
Teacher:	Grade:	School:

BUS INFORMATION

Bus # to school: _____ Bus # from school: _____ Additional Bus #'s: _____

Emergency actions while the student is on the bus:

- ☐ Follow the emergency action plan below.
- ☐ Other: _____

SEIZURE INFORMATION

Seizure Type	How long does it last?	How often?	What Happens?

Seizure Triggers: _____

POSSIBLE SIGNS AND SYMPTOMS

- Aura - warning sign of impending seizure
  Student specific: _____
- Change in consciousness/awareness/alertness (confusion, difficulty thinking/remembering)
- Change in color of skin (pale/blue/gray)
- Staring, eye twitching/blinking/rolling
- Drooling
- Body becomes stiff or limp
- Uncontrollable jerking, shaking or twitching movements
- Loss of bladder and/or bowel control
- Repetitive movements (lip smacking, chewing)
- Psychological symptoms (fear, anxiety or deja vu)
- Additional symptoms (specific to student):
  _____

EMERGENCY ACTIONS

- **Call 911 for:**
  - Absence of breathing or pulse, begin CPR
  - Seizure lasting longer than 5 minutes
  - Multiple seizures with no recovery between them
  - Seizure not responding to medication, if used
  - Pale or bluish skin/lips or noisy breathing continuing after the seizure has stopped
- **Do not restrain student**
- **Do not force objects or fingers into mouth**
- Administer emergency medication, if ordered
- Notify school nurse, if available
- Follow Seizure First Aid
  - **STAY**
    - Stay with the student until they are awake and alert after the seizure
    - Time the seizure
    - Remain calm
    - Check for medical ID
  - **SAFE**
    - Keep the student SAFE
    - Move or guide away from harm
  - **SIDE**
    - Turn the student onto their SIDE if they are not awake and aware
    - Keep airway clear. Loosen tight clothes around neck
    - Put something small and soft under the head
- Observe and if able write down the details of the seizure: duration, kind of movement or behavior, parts of body involved, loss of consciousness.
- Contact parent/guardian
- Additional Actions (specific to student): _____
  _____

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Student Name: _____ D.O.B._____

STUDENT'S ORDERED EMERGENCY MEDICATIONS FOR SCHOOL		
Emergency Medication: ☐ Yes ☐ No		Self-Carry: ☐ Yes ☐ No
Name of Emergency Medication:		
Location of Emergency Medication:		
Additional Medication/Procedure Notes:		

CONTACT INFORMATION	
Parent/Guardian #1:	Parent/Guardian #2:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Emergency Contact:	Phone:

Physician's Name/Signature:	Physician's Phone #:
Parent/Guardian Signature:	Date:
School Nurse Signature:	Date:

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Student Name: _____ D.O.B._____

Emergency Action Plan (EAP) was reviewed by the following staff, and applicable training was provided. Training included: _____			
Date	Name	Job Title/Position	School Nurse Signature