Steilacoom Historical School District

Seizure Action Plan

Child's Name: _____Date of Birth: _____

Place Photo here

Family to complete this page:

Parent/Guardian:_____ Phone: _____

Parent/Guardian:_____ Phone: _____

Primary provider:_____ Phone: _____

Specialist:_____ Phone: _____

Hospital Preference: _____

Important medical history to know: (include hospital stays, surgeries, etc)_____

_____

_____

_____

_____

Special Considerations and Safety Concerns (for activities, sports, trips, etc.)

_____

_____

_____

_____

What my child's seizures look like:	During a seizure, my child needs:	After a seizure my child needs:
	Basic Seizure First Aid: Stay calm & track time Keep my child safe Do not restrain my child Do not put anything in mouth Stay with my child until fully awake Record seizure in log <u>For tonic-clonic (grand mal) seizure:</u> Protect head Keep airway open/watch breathing Turn my child on side	

Please share the information on both pages of this form with the following people at school:

_____

I understand the nurse may communicate with the provider for questions or clarifications of the medications orders (this is standard practice and no release of information is needed).

Parent Name and Signature: _____Date: _____

This section to be completed by the child's Nurse Practitioner or Physician:

Daily Medicines	Dose & Time of Day Given	Common Side Effects & Special Instructions

Does your child have a **Vagus Nerve Stimulator (VNS)**? ☐ Yes ☐ No If yes, please see VNS Sheet
Additional Comments:
_____

Emergency Medicines

Name of medicine	How to give & How much	When to give	Common Side Effects & Special Instructions

Treat my child's seizure as an emergency if:	For a seizure emergency:
A convulsive (tonic-clonic) seizure lasts longer than 5 minutes My child has many seizures in a row without waking up My child is injured My child has breathing difficulties My child has a seizure in water Other:	☐ Call 911 transport to : _____ ☐ Notify parent or this emergency contact: Name: _____ Number: _____ ☐ Notify doctor: _____ ☐ Administer emergency medicines as indicated above ☐ Other: _____ _____ _____ _____

Physician Name and Signature: _____ Date: _____

This form is active from _____ to _____.