CANNON
SCHOOL

Seizure Emergency Action Plan

Student's Name: _____ Date of Birth: _____ Bus number: _____ Grade: _____ School Year: _____
Parent/Guardian's Name: _____ Phone Number: _____
_____ Phone Number: _____
Physician's Name: _____ Phone Number: _____
Emergency Contact #1_____ Emergency Contact #2_____

What type of seizure does your child have?_____ How often do the seizures occur? _____
Describe a typical seizure: _____
How long has it been since his/her last seizure (date)?_____ Age when diagnosed: _____
Does he/she have an aura/warning sign before having a seizure? _____ Please describe: _____
Are any triggers associated with the seizure? Please list:_____
Are there any activity restrictions? Yes No If yes, please attach a physician's note

Medication Name	**Dose/Amount of medication**	**How often?**	**Will medication be needed at school? *attach medication authorization form**

Does student have a Vagus Nerve Stimulator (VNS)? _____ Where is the magnet worn?_____
Describe use of the magnet? _____

SIGNS OF A SEIZURE*: PLEASE CHECK BEHAVIORS THAT APPLY TO YOUR CHILD*

SIMPLE SEIZURES	GENERALIZED SEIZURES	**DANGER SIGNS- CALL 911**	BEHAVIORS EXPECTED AFTER SEIZURES
o Lip smacking o Behavioral outbursts o Staring o Twitching o Other:_____	o Sudden cry or squeal o Falling down o Rigidity/Stiffness o Thrashing/Jerking o Loss of bowel/bladder control o Shallow breathing o Stops breathing o Blue color to lips o Froth form mouth o Gurgling or grunting noises o Loss of consciousness o Other:_____	• Seizure lasts more than 5 minutes • Another seizure starts right after the 1st seizure • Loss of consciousness • Stops breathing • If student has diabetes • If seizure is the result of an injury or child is injured during the seizure • If student is pregnant • If student has never had a seizure before	• Tiredness • Weakness • Sleeping, difficulty to arouse • Somewhat confused • Regular breathing • Other:_____ **ALL OF THE ABOVE CAN LAST A FEW MINUTES TO A FEW HOURS**

IF YOU SEE THIS	**DO THIS**
SEIZURE ACTIVITY	*Stay calm. Move surrounding objects to avoid injury. Do not hold the student down or put anything in the mouth. Loosen clothing as able. After seizure stops, **roll student on his/her side**. Please **document seizure activity on the back of this form**. If applicable, administer medications as ordered. Notify parent/guardian.*
STOPS BREATHING	*Begin CPR/Rescue breathing. Call 911*
LOSS OF BOWEL OR BLADDER CONTROL	*Cover with a blanket or jacket. IF necessary, discreetly assist with changing of clothes after the seizure.*
DANGER SIGNS-SEE ABOVE	*Call 911. Then call parent/guardian*
FALLS DOWN, LOSS OF CONSCIOUSNESS	*Help student to the floor for observation and safety*
VOMITING	*Turn on side*

SIGNATURES	DATE	PARENT SIGNATURE	NURSE SIGNATURE	GRADE/TEACHER
PLAN INITIATED				
1st REVIEW				
2nd REVIEW				