Individualized Seizure Action Plan (SAP) for the 20_____-20_____ School Year

This student is being treated for a seizure disorder. The information provided below is intended to assist school personnel should a seizure occur during school hours.

The Following is to be Completed by the Parent

Student's Name_____ DOB_____ Age_____

Grade_____ Homeroom/Teacher _____

Allergies_____

Significant Medical History_____

Parent/Guardian _____ Phone Number _____

Parent/Guardian _____ Phone Number _____

The Following is to be Completed by the Medical Provider

Seizure Type _____ Date of Seizure Diagnosis _____

Other Medical Diagnosis _____

How long does a seizure typically last? _____ How often? _____

What happens/typical symptoms? _____

Current Medication(s) _____

_____

Special Considerations/Safety Precautions while at school (including after-school care programs, field trips – addition space provided on page 2): _____

_____

_____

<u>Student Specific Seizure Emergency Plan Per Medical Provider</u>

If seizure (cluster, # or length) _____

Name of rescue medication/dose _____

Dosing instructions _____

Special instructions/considerations if rescue medication is given (when to call EMS, etc.): _____

_____

_____

***Continued Page 2**

SPECIAL INSTRUCTIONS

First Responders: _____

_____

Emergency Department: _____

_____

- ❑ **First Aid – Stay. Safe. Side.**
- ❑ **Give rescue therapy according to Emergency Plan per Medical Provider**
- ❑ **Notify emergency contact at #_____**
- ❑ **Call 911 for transport to _____**
- ❑ **Other _____**

Special Considerations/Safety Precautions while at school (Continued): _____

_____

_____

_____

_____

Treating Physician _____ Phone _____ Fax _____

Physician Signature _____ Date _____

Parent Signature _____ Date _____

School Nurse Signature _____Date _____ (rev 4/2023)