SEIZURE ACTION PLAN

Oakdale Joint Unified School District
168 South 3rd Avenue, Oakdale CA 95361
(209) 848-4884 Fax: (209) 847-0155

Student Name: _____
Birthdate: _____
School: _____ Year: _____
Phone (209) _____ Fax (209) _____

Place Picture Here

☐ BUS RIDER ☐ SPORTS ☐ AFTERSCHOOL PROGRAM / CLUB

This student is being treated for a seizure disorder. Information below may be used if a seizure occurs during school hours or at school activities.

Parent/Guardian: _____ Phone: _____ Cell: _____
Primary Physician: _____ Phone: _____ Fax: _____
Neurologist: _____ Phone: _____ Fax: _____

PHYSICIAN COMPLETES FORM FROM THIS POINT FORWARD

Significant Medical History: _____

Seizure Type	Length	Frequency	Description	Date of Last Seizure

Seizure triggers or warning signs: _____

SEIZURE BASIC ➡ ➡ ➡

Student Response after a Seizure:

_____
_____
_____

Does student need to leave classroom after a seizure? ☐ Yes ☐ No
If YES, describe process for returning student to classroom:

_____
_____
_____

SEIZURE RESPONSE - BASIC

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

Tonic-Clonic Seizure additional response:

- Protect Head
- Turn on Side
- Keep Airway Open
- Monitor Breathing

SEIZURE EMERGENCY

A 'Seizure Emergency' for this student is defined as:

_____
_____
_____
_____

SEIZURE EMERGENCY CALL 911 ➡

- 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

SEIZURE RESPONSE – EMERGENCY

- **Call 911 after _____ minutes**
- Contact school office/school nurse
- Administer emergency medications if ordered
- Office to notify parents/guardian or emergency contact on ER card

Other _____

In case of disaster, a 3 day supply of medications must be provided

Emergency Medication:	Dosage & Time Given:	Common Side Effects & Special Instructions:
Daily Medication:	Dosage & Time Given:	Common Side Effects & Special Instructions:

DIASTAT Medication: If prescribed, go to http://www.oakdale.k12.ca.us/Forms and Medication Authorization Form (regular)

Does student have a Vagus Nerve Stimulator? Yes No If YES, provide VNS protocol

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

Physician Signature: _____ **PRINTED NAME:** _____ **DATE:** _____

This form authorizes medication to be given during school hours, on extended field trips or in the incidence of a public disaster i.e., earthquakes. I consent to communication and exchange of information between my physician and Oakdale Joint Unified School District to discuss and share record/conditions pertaining to the above. I understand that this information is confidential and may not be given to employees of other schools public agencies or individual professionals in private practice without my consent. Ed Code 49480

This Form Must Be Renewed Annually or With Any Change in Treatment or Medication

Parent/Guardian Signature: _____ ***Date:*** _____

10/11/2015

For School Use Only ***Date Reviewed:*** _____ ***Initials:*** _____