SEIZURE ACTION PLAN

Los Gatos-Saratoga UNION HIGH SCHOOL DISTRICT

Student's Name_____ Date of Birth_____

Parent/Guardian _____ Cell_____ Other _____

Other Emergency Contact _____ Cell _____ Other _____

Treating Physician _____ Phone _____

Significant Medical History _____

Seizure Type	Description	Frequency	Duration	Date of Last Seizure

Seizure triggers or warning signs: _____

Student's response after a seizure: _____

Basic First Aid:

Care and Comfort

- Stay calm and record time of seizure. Protect dignity of child by shielding if in public.

Keep child safe:

- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Describe seizure in log
- Other:_____

For tonic-clonic seizure:

- Protect head
- Keep airway open
- Monitor breathing
- Turn child on side

Seizure Emergency for this student is described as:

Seizure Emergency Protocol:

- Administer emergency medications if indicated
- Contact School Nurse at _____
- Notify parents and site administrator

Call 911:

- If seizure lasts more than _____ minutes
- If first time seizure
- If student has repeated seizures without regaining consciousness.
- If student is injured, has diabetes, or is pregnant.
- If student has difficulty breathing.
- If student has a seizure in water
- Other: _____

Emergency Medication	Medication	Dosage & Time Given	Common Side Effects & Special Instructions
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Health Care Provider Signature:_____ Phone:_____ Date:_____

School Nurse Signature: _____ Phone:_____ Date:_____

Parent Consent for Seizure Management in School

As the parent or guardian of the above named student, I request that the school assist with the above plan, including the administration of any medication(s), as directed above and in accordance with all state laws and regulations. The school nurse may communicate with the above health care provider about this student when necessary. (Ed Code section 49423 and 49480)

All procedures will be accordance with state laws and regulation. This authorization is valid for one year.

Parent Signature:_____ Phone:_____ Date:_____