FRHSD Seizure Action Plan

Effective Date: _____

This child is being treated for a seizure disorder. This information below should assist you if a seizure occurs.

(Please note that Seizure Action Plans must be updated each school year.)

Child's Name: Date of Birth:

Parent/Guardian Name: Home Phone Number: Cell Number:

Other Emergency Contact: Home Phone Number: Cell Number:

Treating Physician: Phone Number:

Significant Medical History:

Seizure Information:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:_____

Child response after a seizure:_____

Basic First Aid: Care and Comfort

Please describe basic first aid procedures:

Does the child need to leave the other children to recover? ____ YES ____ NO

If YES, describe the process for returning child to interact with others:

Basic Seizure First Aid:
- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious

For tonic-clonic seizure:
- Protect Head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this child is defined as:	**Seizure Emergency Protocol:** (Check all that apply and clarify below) _____ Call 911 for transport to _____ _____ Notify parent or emergency contact _____ Administer emergency medications as indicated below _____ Notify doctor _____ Other _____

A seizure is generally considered an emergency when:
- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Child has repeated seizures without regaining consciousness
- Child is injured or has diabetes
- Child has a first-time seizure
- Child has breathing difficulties
- Child has a seizure in water

FRHSD Seizure Action Plan

Effective Date: _____

This child is being treated for a seizure disorder. This information below should assist you if a seizure occurs.

(Please note that Seizure Action Plans must be updated each school year.)

Treatment Protocol During School Hours (include daily and emergency medications)

Emergency Medication	***Daily Medication***	***Dosage & Time of Day Given***	***Common Side Effects & Special Instructions***

Does this child have a Vagus Nerve Stimulator? _____ YES _____ NO

*If yes, describe magnet use:*_____

(REQUIRED) Special Considerations and Precautions regarding after school activities, sports, trips and bus transportation: *Please explain the treatment protocol below-MUST CIRCLE ONE and include any basic seizure first aid and next steps.*

School Transportation (*MUST CIRCLE ONE and include any basic seizure first aid and next steps.)*:

NO nurse required and NO medication required OR Nurse and medication required

_____

_____

Before and After School Activities/Sports (*MUST CIRCLE ONE and include any basic seizure first aid and next steps.)*:

NO nurse required and NO medication required OR Nurse and medication required

_____

_____

School Trips (*MUST CIRCLE ONE and include any basic seizure first aid and next steps.)*:

NO nurse required and NO medication required OR Nurse and medication required

_____

_____

Physician Name: _____

Physician Signature: _____ Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

By signing this document you give the school permission to release this information to all necessary personnel.

For School use only: Date Received: _____

Name of person receiving plan: _____

Signature of person receiving plan: _____