



Seizure Action Plan (2023-2024)

(Please print)

School: _____

Name	Date of Birth	Effective Date
Healthcare Provider Name:	Parent/Guardian Name:	Emergency Contact Name:
Healthcare Provider Phone Number/Fax Number:	Parent/Guardian Phone Number:	Emergency Contact Phone Number:

Seizure information			
Seizure Type	Length	Frequency	Description

Triggers or warning signs: _____

Student's response after a seizure: _____

Basic First Aid: Care & Comfort	Seizure Emergencies (When to call 911)
<ul style="list-style-type: none"> • Ensure patient is in a safe position with no sharp objects nearby (ease to the floor) • Remove eyeglasses • Place something soft and flat under the patient's head • Remove any tight clothing or jewelry that may be around patient's neck • Do not forcibly hold the person down • If lying down, turn them to their side to prevent choking • Stay with the person until the seizure is over and record how long it lasts • Do not put anything in patient's mouth 	<ul style="list-style-type: none"> • Convulsive seizure lasts more than 5 minutes (not responding to rescue medication if applicable) • Student has another seizure soon after the first one • Student is injured • Student has diabetes, cardiac condition, or is pregnant • Student has first time seizure • Student has difficulty breathing or waking after the seizure • Student has a seizure in water

Seizure Treatment

If the student has a seizure at school:

<input type="checkbox"/> Contact the school nurse	<input type="checkbox"/> Notify Healthcare Provider
<input type="checkbox"/> Administer Emergency Medications as indicated below	<input type="checkbox"/> Notify parent/guardian or emergency contact
<input type="checkbox"/> Call 911:	<input type="checkbox"/> Other:

Treatment Protocol During School Hours (daily and emergency medications)

Emergency Med (✓)	Medication/Route/Frequency	Dosage and Time of Day Given	Common Side Effects and Special Instructions

Does the student have a Vagus Nerve Stimulator? Yes No If yes, describe use: _____

Special Considerations and Precautions (regarding school activities, sports, trips, diet, etc.) Please describe below:

Healthcare Provider Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____