

Seizure Action Plan

Student Name: _____ Date of Birth: _____
 School: _____ School Phone #: _____ School Fax: _____
 Parent/Guardian: _____ Home Phone: _____ Cellular: _____
 Emergency Contact: _____ Home Phone: _____ Cellular: _____
 Primary Physician: _____ Phone: _____ Fax: _____
 Neurologist: _____ Phone: _____ Fax: _____

This student is being treated for a seizure disorder. The information below may assist if a seizure occurs during school hours or at school activities.

PHYSICIAN COMPLETES FORM FROM THIS POINT FORWARD.

Significant Medical History: _____

Seizure Information				
Seizure Type	Length	Frequency	Description	Last Seizure Date

Seizure triggers or warning signs: _____

Student's response after seizure: _____

Seizure – BASIC <ul style="list-style-type: none"> Stay calm and record start 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 child's head * Turn child on side * Keep airway open * Monitor breathing	Additional Individual Student Information: Parent requests notification after each seizure ____ Yes ____ No Student needs to leave classroom after a seizure ____ Yes ____ No IF YES, describe process for returning student to classroom: _____ In case of incontinence, parent should provide extra clothing for school so student may return to class as allowed by process above. ____ Yes ____ No
Seizure Response – EMERGENCY ____ Call 911 for Paramedics ____ Contact school nurse ____ Administer emergency medications if indicated below ____ Notify parents or emergency contact (as listed above) ____ Notify doctor listed above ____ Other: _____	A Seizure is Generally Considered an Emergency if: Convulsive (tonic-clonic) seizure lasting longer than 5 minutes Student has repeated seizures without gaining 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

A "seizure emergency" for this student is additionally defined as: _____

Treatment Protocol During School Hours or School Activities (include daily and emergency medications*)			
*Emergency Med?	*Medication Name	Dosage and Time of Day to be Given	Common Side Effects and Special Instructions
☐ Yes ☐ No			
☐ Yes ☐ No			
☐ Yes ☐ No			

Does student have a Vagus Nerve Stimulator? ☐ Yes ☐ No If YES, describe magnet use/location: _____

Call 911 if still seizing after ____ SNS swipes. Wait ____ minutes between swipes. Give ____ swipes before any emergency medication.

Special Considerations and Precautions (regarding bus ride)

Describe any special considerations or precautions: _____
 Rectal Diastat* (If Ordered): Should Diastat be administered on bus? ☐ Yes ☐ No If no, please list actions to be taken by bus driver and/or bus aide: _____

Please note Administration of Emergency Rectal Medication may not be possible on a bus due to safety issues. EMS has protocols in place for Seizure Emergencies.

Physician Name/ Signature: _____ Date: _____

I give permission for school staff to contact the physician for consultation and exchange of information as needed.

Parent/Guardian Signature: _____ Date: _____

Signature of Health Services Personnel: _____ Date: _____

This form must be renewed annually or with any change in treatment or medication.

*The Medication Administration Form must be completed in addition to the Seizure Action Plan if medication is required at school or school activities.