SEIZURE ACTION PLAN

Student Name: ________________________________

Contact Immediately After a Seizure

School Nurse Name: __________________________ Phone Number: __________________
(Or other designated individual on-site all school day)

General Information

School Name: __________________ School Year: __________ Student Grade Level: _____
Classroom(s): ________________________________________________________________
Parent/Guardian Name: _______________________________________________________
Primary Phone: ______________ Secondary Phone: ______________
Other Emergency Contact: ______________________________________________________
Primary Phone: ______________ Secondary Phone: ______________
Child’s Neurologist: __________________________________________________________
Phone: __________________________ Location/Clinic: ___________________________
Child’s Primary Care Dr: ______________________________________________________
Phone: __________________________ Location/Clinic: ___________________________
What’s the best way to communicate with you about your child’s seizures? ______________
Can this information be shared with classroom teacher(s) and the appropriate personnel? YES NO
Do school personnel have permission to contact your child’s physician? YES NO

Seizure Information

<table>
<thead>
<tr>
<th>Seizure Type/Name</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
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Seizure Triggers/Warning Signs: ________________________________

Medication/Treatment Protocol

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<tr>
<th>Medication Name</th>
<th>Emergency Med?</th>
<th>Dosage &amp; Time Given</th>
<th>Administration Method</th>
<th>Common Side Effects/ Special Instructions</th>
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Does your child have a Vagus Nerve Stimulator (VNS)? YES NO
If yes, describe magnet use: ________________________________________________
Seizure First Aid/Proper Response

Respond to a seizure by: ____________________________________________________________

Do they need to leave the room/area after a seizure? YES  NO

If yes, describe the process for returning: _____________________________________________

Emergency Response

A “seizure emergency” for your child is defined as: ____

Seizure Emergency Protocol Includes:

☐ Call 911 for transport to: ________________________________________________________
☐ Notify parent or emergency contact
☐ Notify doctor
☐ Administer emergency medication indicated on front page
☐ Other: _______________________________________________________________________

General Seizure Information

How often does your child have seizures? ________________________

Has there been any recent changes in their seizure pattern? YES  NO

If yes, please explain: ____________________________________________________________

What should be done if your child misses a medication dose? ___________________________

Should the school have backup medication available if they miss a dose? YES  NO

Do you wish to be called before backup medication is given for a missed does? YES  NO

Special Considerations/Precautions

Note any special considerations related to your child’s epilepsy while at school:

☐ General Health: ______________________________  ☐ Physical Education(Gym): ______________
☐ Physical Functioning: __________________________  ☐ Recess: _______________________________
☐ Learning: ______________________________________  ☐ Field Trips: ____________________________
☐ Behavior: ______________________________________  ☐ Bus Transportation: _____________________
☐ Mood/Coping: ________________________________
☐ Other: ______________________________________

Parent Signature: ____________________________  Date: ______________  Dates Updated: _________

Physician Signature: _________________________  Date: ______________

For additional epilepsy and seizure information, contact the Epilepsy Foundation of Minnesota at info@efmn.org or 651.287.2300.