



ALEXANDRIA Public Schools

Our Mission

To achieve educational excellence and to inspire a life-long passion for learning.

Our Vision

To be an extraordinary school district that tailors learning for each child, by working together!



SEIZURE ACTION PLAN

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name:	Date of birth:	School year:
Parent/Guardian Name:	Phone #:	
Treating Physician:	Address & Phone #:	Cell #:
Significant medical history:		

SEIZURE INFORMATION:

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

BASIC FIRST AID: CARE & COMFORT:

(Please describe basic first aid procedures)

Does the student need to leave the classroom after a seizure?

Yes No

If YES, please describe the process for returning student to the classroom:

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
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:

- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side



EMERGENCY RESPONSE:

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

A Seizure is generally considered an Emergency when:

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first-time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

Contact school nurse at: 320-762-2141 ext. 4135 or 320-760-2621

Call 911 for transport to: Alomere Health

Notify parent or emergency contact

Notify doctor: _____

Administer emergency medications as indicated below

Other: _____

TREATMENT PROTOCOL: *(include daily and emergency medications).*

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

Emergency/Rescue Medication: _____

Does student have a Vagus Nerve Stimulator (VNS)? Yes No

If YES, describe magnet use: _____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.,)*

Physician Signature:	Date:
Parent/Guardian Signature:	Date:
Health Paraprofessional Signature:	Date:
RN Signature:	Date: