GODLEY
HEALTH SERVICES

Emergency Seizure Action Plan

Student Name: _____ DOB: _____ Grade: _____
Parent/Guardian: _____ Preferred Number: _____
Emergency Contact: _____ Preferred Number: _____
Physician: _____ Phone: _____ Fax: _____
Significant Medical History: _____

SEIZURE INFORMATION

(to be completed by Parent/Guardian)

When was your child diagnosed with seizures/epilepsy? _____
Warning signs/triggers/behavioral changes before seizures? _____
Describe your child's typical seizure: _____
Date of last seizure: _____
How does your child act after a seizure: _____
Recent changes in your child's seizure pattern? If so, please explain: _____
Does he/she have a Vagus nerve stimulator? (If so, please describe): _____
Describe your child's level of understanding of their seizures and their ability to manage them: _____

_____

Special considerations and/or precautions: _____
Additional Information: _____

What routine medications does your child currently take?

Medication	Date Started	Dose	Frequency	Possible Side Effects

What emergency/rescue medication does your child take?

Medication	Date Started	Dose	Frequency	Possible Side Effects

SEIZURE EMERGENCY RESPONSE

(to be completed by **Health Care Provider**)

Seizure type(s):

Seizure Type	Length	Frequency	Description

Does the student have a vagus nerve stimulator? If yes, describe use: _____

_____

Describe any special considerations or precautions regarding school activities, sports, trips, etc.: _____

_____

Student Name: _____ DOB: _____

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What constitutes a seizure emergency: _____

_____

Medications to be administered at school in case of seizure:

Medication Name	Dose	Administration instructions (timing and method)	What to do after administration

Actions to be taken after seizure (postictal period): _____

_____

_____

Additional basic first aid measures, including if the child needs to leave the classroom after a seizure occurs/the process for the child's return to the classroom: _____

_____

Call 911 if:

- Seizure does not stop by itself within ___ minutes
- Seizure continues after VNS use for _____ minutes
- Child does not wake up within _ minutes following seizure (NO emergency medication given)

Physician Signature: _____ Date: _____

Basic Seizure First Aid	**A seizure is considered an emergency when:**
• Stay calm, TIME THE SEIZURE • Assist student to the floor, keep safe • Protect student's head • Keep airway open/monitor breathing • Turn child on side • Do not restrain • Do not put anything in mouth • Stay with child until fully conscious	• Child has never had a seizure before • Convulsive (tonic-clonic) seizure lasts longer than 5 seizures • Child has repeated seizures without regaining consciousness • Child is injured or has diabetes • Child has breathing difficulties • Child has seizure in water

- If emergency medication is administered 911 will be called and parent/guardian notified
- If prolonged seizure occurs at any time when a school nurse (RN or LVN) is not available 911 will be called and parent/guardian notified

THIS SECTION REQUIRES A PARENT/GUARDIAN SIGNATURE

***Notice of Parent and Student Rights Under Section 504**: Based on information provided on this Emergency Action Plan, your child may be eligible for Section 504 consideration. Please review the attached Notice of Parent & Student Rights Under Section 504 of the Rehabilitation Act of 1973. If you have any questions about Section 504 eligibility or the evaluation process, please contact the 504 Coordinator at your child's campus. Signature on this form indicates receipt of rights.

***Notice To Parent/Guardian of Students Attending Multiple Campuses**: Students who attend multiple campuses during the school day and who require "as needed" medications should have medications available at both campuses . The parent is required to deliver the medication to both campuses and meet with both school nurses to review the student's individual needs.

***This form must be updated every year. A new school year means a new form will be necessary.**

***I consent to the above treatment plan and authorize designated school staff to administer the listed medication(s).**

Parent/Guardian Signature: _____ Date: _____

Student Name: _____ DOB: _____