EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

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 _____

Parent/Guardian _____ Phone _____ Cell _____

Other Emergency Contact _____ Phone _____ Cell _____

Treating Physician _____ Phone _____

Significant Medical History _____

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ☐ Yes ☐ No

If YES, describe process for returning student to 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 seizure:

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

Emergency Response

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

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

- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify doctor
- ☐ Other _____

A seizure is generally considered an emergency when:

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

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

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

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

DPC772

FORM S-100

Seizures
Individual Child Care Plan

Child's Name: _____ Date of Birth: __/__/__

EMERGENCY PHONE NUMBERS

Parent/Guardian #1: _____
Name Home # Work # Other #

Parent/Guardian #2: _____
Name Home # Work # Other #

(See emergency contact information for alternate if parents are unavailable)

Primary health care provider's name: _____ emergency phone: _____

Specialist's name (if any): _____ emergency phone: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Type of Seizure/Diagnosis: _____ Date of onset: __/__/__

Current health concerns: _____

_____

Conditions that trigger the seizures: _____

_____

Description of Seizures:

- Behavior before the seizure: _____
- During the seizure: _____
- Length of typical seizure: _____
- After the seizure: _____

First Aid during and after seizure: _____

_____

Are seizures controlled by medications? Yes _____ No
(Name of Medication)

Does the medication need to be given while in attendance at child care? Yes No

Medication: _____	Medication: _____
Amount: _____	Amount: _____
Schedule/Time: _____	Schedule/Time: _____
Action: _____	Action: _____
Possible side effect: _____	Possible side effect: _____
When to call 911: _____	**When to call 911:** _____

Are there any activity restrictions? _____

_____

Other pertinent information: _____

Physician's signature: _____ Date: __/__/__

- Over -

I give my permission for the provider to follow this plan of care prescribed by the physicians. I also give my permission to call the health care provider(s) indicated for any additional medical information about my child.

_____ ___/___/___

signature of child's parent/guardian *date signed*

TRAINED CHILD CARE PROVIDERS:

Name: _____ Room: _____

Name: _____ Room: _____

Plan of care reviewed by:

Director: _____ Date: ___/___/___

Teacher: _____ Date: ___/___/___

Child Care Health Consultant: _____ Date: ___/___/___

Date of re-evaluation (every six (6) months or sooner if needed): Date: ___/___/___

Paterson Public Schools
Department of Early Childhood Education
Preschool Activity Limitation Form

STUDENT_____ DOB:_____ GRADE_____

Dear Doctor:
Our records indicate that the above named student requires an individual activity plan. Please provide a diagnosis and what accommodations, if any are needed. Will you kindly check below the activities that the student may participate?

PROGRAM OF FULL PARTICIPATION with NO RESTRICTIONS: _____YES _____NO

Relating to DIAGNOSIS: _____

PHYSICIAN PRINT/STAMP_____ phone:_____

PHYSICIAN SIGNATURE:_____DATE:_____

Or:

PROGRAM OF RESTRICTED ACTIVITY: **Start Date**_____ **End Date**_____

Relating to DIAGNOSIS: _____ **,the following plan is indicated.**

Student MAY PARTICIPATE in the following activities:	Yes	No
WARM UP EXCERCISES: Stretching, walking		
LOW IMPACT AEROBIC: jumping, hopping, dance		
Stunts: tumbling, rolling on mats		
Non-Contact games: jump rope, ball (no hard balls used)		
Gym: free play, use ball (no hard balls used)		
Apparatus: low balance beam, tricycle, scooter		
Climbing: Max height on slide 48 inches, rock crawl (40") little tikes apparatus		
Outdoor play: swing, slide, running , free play		

Stair climbing (circle) YES NO * number of flights of stairs per day_____

USE OF HELMET : GYM ___Yes ____No RECESS: ____Yes ___NO IN CLASS___Yes__No

Other protective/assistive devices (please specify):_____

Other restrictions:_____

PHYSICIAN PRINT/STAMP:_____PHONE:_____

PHYSICIAN SIGNATURE:_____ DATE:_____

Approved by School Physician_____ Date_____