



SEIZURE ACTION PLAN

Effective Date: _____

**This student is being treated for a seizure disorder.
This information below should assist you if a seizure occurs during school hours.**

Student's Name: _____	Date of Birth: _____
Parent/Guardian: _____	Phone: _____
Other Emergency Contact: _____	Cell: _____
Treating Physician: _____	Phone: _____

Significant Medical History: _____

SEIZURE INFORMATION			
Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____ Student's reaction to seizure(s): _____

BASIC FIRST AID: CARE AND COMFORT

Please describe basic first aid procedures: _____

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

If YES, describe the process for returning to the classroom: _____

A seizure is generally considered an Emergency when:

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

Basic Seizure First Aid

- ✓ Stay calm and track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record in seizure log

For tonic-clonic (grand mal) seizure:

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

When to call the student's doctor first:

- ✓ A change in seizure type, number, or pattern
- ✓ Student does not return to usual behavior (i.e., confused for a long period)
- ✓ A first-time seizure that stops on its own
- ✓ Other medical problems or a pregnancy needs to be checked

EMERGENCY RESPONSE	
A "seizure emergency" for this student is defined as:	Seizure Emergency Protocol (Check all that apply and clarify below) <input type="checkbox"/> Contact school nurse at _____ <input type="checkbox"/> Call 911 for transport to _____ <input type="checkbox"/> Notify parent or emergency contact <input type="checkbox"/> Administer emergency medications as indicated below <input type="checkbox"/> Notify doctor <input type="checkbox"/> Other

TREATMENT PROTOCOL DURING SCHOOL HOURS (include daily and emergency medications)			
Emergency 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
 Devices: VNS RNS DBS Date Implanted: _____
 Magnet Use Instructions: _____

STUDENT'S RESPONSE AND CARE AFTER A SEIZURE

What type of help is needed? _____
 When is the student able to resume usual activity? _____
 Does the student need to leave the classroom? Yes No
 If YES, when can the student return to the classroom? _____
 Is the student able to manage and understand their seizures? Yes No

SPECIAL INSTRUCTIONS

First Responders: _____
 Emergency Department: _____

DAILY SEIZURE MEDICATION

Medication Name	Dosage	Time to be Given	Common Side Effects	Special Instructions

OTHER INFORMATION

Important Medical History: _____
 Allergies: _____
 Epilepsy surgery (type, date, side effects): _____
 Diet therapy: Ketogenic Low-Glycemic Modified Atkins Other: _____
 Special considerations, instructions, or precautions (i.e., school trips, activities, sports, etc.): _____

HEALTH CARE CONTACTS

Epilepsy Provider: _____	Phone: _____
Primary Care: _____	Phone: _____
Preferred Hospital: _____	Phone: _____
Pharmacy: _____	Phone: _____
Parent/Guardian Signature: _____	Phone: _____
Physician Signature: _____	Phone: _____