

NAME: \_\_\_\_\_

**SEIZURES**  
**EMERGENCY ACTION PLAN**

**SYMPTOMS:**            **ABSENCE (PETIT MAL):** Brief loss of consciousness, minimal or no alteration in muscle tone, usually able to maintain postural control, frequently has minor movements or twitching, often mistaken for inattention.

**TONIC-CLONIC (GRAND MAL):** Loss of consciousness, child falls to floor or ground, breathing may stop for a moment, arms and legs may become rigid and move in rhythm with face, may be incontinent of urine and/or feces, may last several minutes, may want to sleep afterwards.

**INTERVENTIONS:**

- 1. Stay with child during and after seizure. Note duration of seizure and type of body movement during seizure episode.**
- 2. Assist to horizontal position if loss of consciousness occurs. Remove glasses, loosen clothing around neck.**
- 3. Turn on side as soon as able.**
- 4. Clear area around child to prevent injury.**
- 5. DO NOT RESTRAIN MOVEMENT OR PLACE ANYTHING IN MOUTH.**
- 6. Monitor breathing and begin rescue breathing if breathing does not resume spontaneously.**
- 7. If seizure lasts more than 5 minutes or student has one seizure after another without waking, call 911 and transport to \_\_\_\_\_ Hospital.**
- 8. When seizure is over, allow child to rest and always notify parents.**
- 9. Notify school nurse if in building.**
- 10. Additional information.**

**In order to make sure my child's special health needs are met, I understand and agree that the information will be shared with school staff/other personnel on a need to know basis in order to provide appropriate care. I understand and agree that the school nurse may contact my child's doctor about this condition.**

**PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

**NURSE \_\_\_\_\_ DATE \_\_\_\_\_**

**SCHOOL SEIZURE RECORD**

NAME OF STUDENT \_\_\_\_\_ SCHOOL \_\_\_\_\_

GRADE/TEACHER \_\_\_\_\_ YEAR \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_ PHONE \_\_\_\_\_

\_\_\_\_\_ PHONE \_\_\_\_\_

HEALTH CARE PROVIDER \_\_\_\_\_ PHONE \_\_\_\_\_

1. Does your child wear a "medic alert" bracelet?  Yes  No
2. What type of seizure does your child have and how often do they occur?
3. Describe your child's symptoms during and after the seizure episode.
4. Does your child have an aura or warning of seizure coming? Is she/he able to notify anyone that a seizure is coming?
5. Name medications taken. How often and how much?  
At Home:  
At School:
6. Does your child suffer any side effects to these medications? Please list:
7. Name any activities in which your child CANNOT participate (DOCTOR'S NOTE REQUIRED)
8. What steps do you want school personnel to take if a seizure should happen?

PLEASE NOTE: If medications are to be taken at school, they must have a prescription label from the doctor, and a medical authorization for must be completed by the doctor and kept at school. Students are NOT allowed to transport medicines. Medical forms may be obtained from the office, and are renewed each year for each medication.

PLEASE READ THE EMERGENCY ACTION PLAN FOR SEIZURES ON THE REVERSE SIDE, AND ADD ANY ADDITIONAL INFORMATION.