

## Seizure Action Plan

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Effective Date \_\_\_\_\_

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Classroom: \_\_\_\_\_

Parent/Guardian/Relative Caregiver: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Treating Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical History: \_\_\_\_\_

### **Seizure Information:**

1. When was your child diagnosed with seizures or epilepsy? \_\_\_\_\_

2. Seizure type(s):

| <i>Seizure Type</i> | <i>Average length</i> | <i>Description</i> |
|---------------------|-----------------------|--------------------|
|---------------------|-----------------------|--------------------|

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|  |  |  |
|  |  |  |

3. What might trigger a seizure in your child? \_\_\_\_\_

4. Are there any warnings, triggers and/or behavior changes before the seizure occurs?    YES    NO  
If YES, please explain: \_\_\_\_\_

5. How often does your child have a seizure? \_\_\_\_\_

6. When was your child's last seizure? \_\_\_\_\_

7. Has there been any recent change in your child's seizure patterns?    YES    NO  
If YES, please explain: \_\_\_\_\_

8. How does your child react after a seizure is over? \_\_\_\_\_  
How long does this usually last? \_\_\_\_\_

9. How do other illnesses affect your child's seizure control? \_\_\_\_\_

### **Seizure Medication and Treatment Information:**

10. What medication(s) does your child take?

| <i>Medication</i> | <i>Date Started</i> | <i>Dosage</i> | <i>Frequency and time of day taken</i> | <i>Possible side effects</i> |
|-------------------|---------------------|---------------|--|------------------------------|
|-------------------|---------------------|---------------|--|------------------------------|

|    |  |  |  |  |
|----|--|--|--|--|
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |

Student's Name \_\_\_\_\_

**Emergency Response:**

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

11. What emergency/rescue medications are prescribed for your child?

| <i>Name</i> | <i>Dosage</i> | <i>Administration instructions</i><br><i>(timing* &amp; method**)</i> | <i>What to do after administration:</i> |
|-------------|---------------|---|---|
| 1.          |               |   |   |
| 2.          |               |   |   |

\* After 2<sup>nd</sup> or 3<sup>rd</sup> seizure, for cluster of seizure, etc.

\*\* Orally, under tongue, rectally, etc.

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

- Contact school nurse at \_\_\_\_\_
- Call 911 for transport to \_\_\_\_\_
- Notify parent or emergency contact \_\_\_\_\_  
Telephone number \_\_\_\_\_
- Notify doctor \_\_\_\_\_  
Telephone number \_\_\_\_\_
- Administer emergency medications as indicated
- Other \_\_\_\_\_

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, has diabetes, or is pregnant
- Student has breathing difficulties

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 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This form combines two forms (one for parents and one for physician) created by the Epilepsy Foundation and the National Association of School Nurses in 2004.