# 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:_____

Treating Physician:_____ Phone: _____

Significant medical history:_____

## SEIZURE INFORMATION:

| *Seizure Type* | *Length* | *Frequency* | *Description* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Seizure triggers or warning signs:_____

Student's reaction to seizure:_____

## BASIC FIRST AID: CARE & COMFORT: *(Please describe basic first aid procedures)*

**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 (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

Does student need to leave the classroom after a seizure? YES☐ NO☐
If YES, describe process for returning student to classroom

## EMERGENCY RESPONSE:

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

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 or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

Seizure Emergency Protocol: *(Check all that apply and clarify below)*
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other_____

## TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

| Daily Medication | Dosage & Time of Day Given | Common Side Effects & Special Instructions |
|---|---|---|
| | | |
| | | |

Emergency/Rescue Medication

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:**_____