

Campus Nurse will
attach
Student Photo



Aledo Independent School District
Health Services Department
Seizure Action Plan

Transportation

- Car Rider Walker
 Bus # _____
 Other: _____

Student has permission to transport
medication listed below to and from
school?

- YES NO

Student's Name		Date of Birth		GRADE	
Parent/Guardian		Phone		Cell	
Other Emergency contact		Phone		Cell	
Significant Medical History:					
Seizure Description (Check all that apply)					
<input type="checkbox"/> Convulsions <input type="checkbox"/> Involuntary rhythmic movements <input type="checkbox"/> Staring <input type="checkbox"/> Unconsciousness <input type="checkbox"/> Stiffening <input type="checkbox"/> Facial tics					
Seizure Type		Length		Frequency	
Seizure triggers or warning signs:			Student's response after a seizure:		
Basic First Aid: Care & Comfort			Basic Seizure First Aid		
Please describe basic first aid procedures:			<ul style="list-style-type: none"> • 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 		
Does student need to leave the classroom after a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No			For tonic-clonic seizure: <ul style="list-style-type: none"> • Protect head • Keep airway open/watch breathing • Turn child on side 		
If Yes, describe process for returning student to classroom:					
Emergency Response					
Name of Emergency Medication:		Seizure Emergency Protocol		A seizure is generally considered an Emergency when:	
_____ Dosage: _____ Route: _____ Administer for seizures lasting for more than _____ minutes.		<ul style="list-style-type: none"> * Contact campus nurse at _____ * Administer emergency medications * Call 911 * Notify parent or emergency contact * Document Episode/Student Accident Report Filed * Other: _____ 		<ul style="list-style-type: none"> • Convulsive (tonic-clonic) seizures 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 	
Medication(s) to be Given During School Hours					
Medication		Dosage		Time to be Given	
Does student have a Vagus Nerve Stimulator ? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, Location GENERATOR _____ MAGNET _____					
VAGUS NERVE STIMULATION (VNS):					
<input type="checkbox"/> Swipe magnet at seizure onset. <input type="checkbox"/> Swipe for report of aura <input type="checkbox"/> Repeat swipe _____ times every _____ minutes. If seizure last 5 minutes, CALL 911 and implement Emergency Response indicated above. <input type="checkbox"/> Other: _____					
<small>KEEP MAGNET 10" AWAY FROM CREDIT CARDS, TELEVISION, CELL PHONES, COMPUTERS, MICROWAVES, WATCHES AND OTHER MAGNETS. THE MAGNET CAN BREAK IF DROPPED. USE THE MAGNET BY MOVING OR PASSING THE MAGNET OVER THE GENERATOR FOR APPROXIMATELY 1 SECOND. THE STUDENT WILL RECEIVE ONE MINUTE OF STIMULATION AFTER EACH MAGNET SWIPE.</small>					
Special Considerations and Precautions (regarding school activities, sports, trips, etc.)					
Describe any special considerations or precautions:					
<input type="checkbox"/> I AGREE with the recommendations of my child's HCP and authorize Aledo ISD staff to deliver treatment as outlined above. <input type="checkbox"/> I DO NOT approve of the standardized procedure(s) and, therefore have attached my alternate written recommendations.					
I give permission for my child's HCP to communicate with appropriate Aledo ISD employees for the current school year.					
Physician Signature		Printed Name		Phone	
Parent/Guardian Signature		Date			

ADDENDUM to Action Plan

NURSE USE ONLY:

- Transportation Notified: Date Faxed _____
- Bus Driver Notified
- Added to Medical Alerts
- Self-Carry
- Diet Modification: Date Faxed _____
- RTI 504 ARD Committee Notified: Date _____

In addition: A full IHP needed for a 504 or an ARD

	Field Trips	Student will be grouped with a trained staff member.
	Before or After School Activities (i.e. Safety Patrol, Clubs, Sports)	Nurse and Parent will discuss a plan for their child.
	Emergency Evacuation of School	Nurse will bring medication/supplies out of building and will attend to student as needed.

◇ TRAINED STAFF MEMBERS ◇

(To be completed by campus personnel)

Teacher's Name:	Date:
Teacher's Name:	Date:
Administrator's Name:	Date:
Office Staff's Name:	Date:
Cafeteria Staff's Name:	Date:
Bus Driver's Name:	Date:
Other Name:	Date:
Other Name:	Date:
Other Name:	Date:

OTHER COMMENTS:

Nurse Signature: _____

Date: _____