



PITTSBURGH PUBLIC SCHOOLS – HEALTH SERVICES

SEIZURE ACTION PLAN FOR SCHOOL

Enter School Year \_\_\_\_\_ Enter Current Date \_\_\_\_\_

LAST NAME		DOB	
FIRST NAME		GENDER: Male <input type="checkbox"/>	Female <input type="checkbox"/> Non- Binary <input type="checkbox"/>
SCHOOL		GRADE	

DATE OF LAST SEIZURE \_\_\_\_\_

**PLEASE DESCRIBE ALL SEIZURE PRESENTATIONS, TYPICAL LENGTH, COMPLICATIONS, ETC.**

(Example: The most common seizures are staring spells occasionally accompanied by chewing mouth movements and turning of the head to the left side. Duration-usually last less than 5 minutes. Afterward, student may be a little sleepy. Student may also have tonic clonic seizures lasting less than 2 minutes.)

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Are there any warnings and /or behavioral changes before a seizure occurs? Yes  OR No  If yes, describe:

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What triggers for seizures should be avoided in school if possible?

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**MEDICATIONS:**

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Are there restrictions or limitations of any school activities (gym, sports, other)? Yes  OR No  If yes, describe:

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For Tonic Clonic seizure activity in school:

1. The student should be carefully placed on their side, and start timing the seizure.
2. Cushion and protect their head and place nothing in the student’s mouth.
3. 911 should be called if the seizure lasts longer than 5 mins. and/or is an unusual occurrence.
4. The school nurse should be informed, and if possible come to the scene.
5. The area should be cleared of nonessential personnel.
6. The parents should be called.

**X** \_\_\_\_\_ **X** \_\_\_\_\_ **X** \_\_\_\_\_  
 NEUROLOGIST SIGNATURE PRINT NAME DATE

DATE PHONE FAX

**X** \_\_\_\_\_ **X** \_\_\_\_\_ **X** \_\_\_\_\_  
 PARENT/GUARDIAN SIGNATURE PRINT NAME DATE

Provide The Best Phone Number(s) To Reach You:

**PARENT/GUARDIAN: PLEASE COMPLETE A RELEASE OF INFORMATION FORM WITH YOUR CHILD’S NEUROLOGIST SO THAT THE SCHOOL NURSE MAY DISCUSS IMPLEMENTATION OF THIS PLAN WITH THE PHYSICIAN.**