SENECA VALLEY SCHOOL DISTRICT
SEIZURE ACTION PLAN

Place

Child's

Photo

Here

Student Name:____ **DOB:**_________________ **Grade:**_________

Parent/Guardian:________________________________ Phone: ______________________ Cell:___________________

Parent/Guardian:________________________________ Phone: ______________________ Cell:___________________

Other contact:____ Phone: ______________________ Cell:__________________________

Primary provider:____ Phone:______________________________________

Specialist:____ Phone:______________________________________

Hospital Preference:____

Significant medical history:____

Daily and Emergency Medicines:

Daily Medicines	Dose & Time of Day Given	Common Side Effects & Special Instructions

Emergency Medicine	How to give & How much	When to give medicine	Common Side Effects / Special Instructions

Do I have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding triggers, activities, sports, trips, etc.)*

SEIZURE INFORMATION:

What do I need to avoid to reduce my seizures? ____

What my seizure looks like?	*What do I need for this?*	*What I need after this?*
	Basic Seizure First Aid: ✓ Stay calm & track time ✓ Keep me/my child safe ✓ Do not restrain me ✓ Do not put anything in mouth ✓ Stay with my/my child until fully awake ✓ Record seizure in log For tonic-clonic (grand mal) seizure: ✓ Protect head ✓ Keep airway open/watch breathing ✓ Turn me/my child on side	
What is a "seizure emergency" for me?	**A seizure is generally considered an emergency when:** ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes ✓ I/my child has repeated seizures without regaining consciousness ✓ I/my child has a first time seizure ✓ I/my child is injured or has diabetes ✓ I/my child has breathing difficulties ✓ I/my child has a seizure in water	☐ Call 911 for transport to closest Hospital ☐ Notify parent or this emergency contact – Name:___________ Number:_________ ☐ Notify doctor ☐ Administer emergency medicines as indicated above ☐ Other_________________

Physician Signature:____ **Clinic:**__________________________________ **Date:**___________

(Required)

Parent Signature:____ **Date:**__________________________

(Required)

1/2011