Seizure Action Plan (2024-2025)

(Please print) School:

Name	Date of Birth	Effective Date
Healthcare Provider Name:	Parent/Guardian Name:	Emergency Contact Name:
Healthcare Provider Phone Number/Fax Number:	Parent/Guardian Phone Number:	Emergency Contact Phone Number:

Seizure information			
Seizure Type	**Length**	**Frequency**	**Description**

Triggers or warning signs: _____

Student's response after a seizure: _____

Basic First Aid: Care & Comfort	Seizure Emergencies (When to call 911)
• **Ensure patient is in a safe position with no sharp objects nearby (ease to the floor)** • **Remove eyeglasses** • **Place something soft and flat under the patient's head** • **Remove any tight clothing or jewelry that may be around patient's neck** • **Do not forcibly hold the person down** • **If lying down, turn them to their side to prevent choking** • **Stay with the person until the seizure is over and record how long it lasts** • **Do not put anything in patient's mouth**	• **Convulsive seizure lasts more than 5 minutes (not responding to rescue medication if applicable)** • **Student has another seizure soon after the first one** • **Student is injured** • **Student has diabetes, cardiac condition, or is pregnant** • **Student has first time seizure** • **Student has difficulty breathing or waking after the seizure** • **Student has a seizure in water**

Seizure Treatment

If the student has a seizure at school:

☐ **Contact the school nurse** ☐ **Notify Healthcare Provider**

☐ **Administer Emergency Medications as indicated below** ☐ **Notify parent/guardian or emergency contact**

☐ **Call 911:**_____ ☐ **Other:**_____

Treatment Protocol During School Hours (daily and emergency medications)

Emergency Med (√)	Medication/Route/Frequency	Dosage and Time of Day Given	Common Side Effects and Special Instructions

Does the student have a Vagus Nerve Stimulator? ☐**Yes** ☐ **No** If yes, describe use:

Special Considerations and Precautions (regarding school activities, sports, trips, diet, etc.) Please describe below:

Healthcare Provider Signature: _____ **Date:** _____

Parent/Guardian Signature:_____ **Date:**_____