Student Photo Here

SEIZURE ACTION PLAN

Student Name _____ Birthdate _____ Grade _____

Effective Date: School Year 20 ___- ___ (including summer school) **OR** From _____To _____

To be completed by a medical practitioner:

EMERGENCY SEIZURE MEDICATIONS

Give medication at □ onset of seizure □ for seizure lasting longer than __ minutes or □ _____

_____

_____

Medication Dosage Route

_____

Medication Dosage Route

BASIC SEIZURE FIRST AID

- Stay calm
- Track time of onset and length of seizure
- Do not restrain child
- Do not put anything in mouth
- Remain with child until fully conscious
- Protect head
- Keep airway open and monitor breathing
- Turn child on side after seizure ends

EMERGENCY RESPONSE

- Follow Basic Seizure First Aid
- Administer emergency medications as indicated above
- Notify parent or emergency contact and school nurse
- Other _____

_____

_____

_____

ALWAYS CALL 911 IF:

- Emergency seizure medication was given
- A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has breathing difficulties
- Student has a seizure in water

SEIZURE INFORMATION

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

DAILY SEIZURE MEDICATIONS TAKEN AT SCHOOL

_____

Medication Dosage Frequency Route

_____

Medication Dosage Frequency Route

SPECIAL CONSIDERATIONS AND SAFETY PRECAUTIONS (school sponsored activities/events, sports, trips)

_____

_____

PARENT/GUARDIAN SIGNATURE _____ Phone _____ Date _____

I hereby give permission to staff designated by the school principal or nurse to give the above medication to my student according to the instructions stated above and authorize them to contact the practitioner, if necessary.

PRACTITIONER SIGNATURE _____ Phone _____ Date _____

Practitioner signature directs the above medication administration and indicates willingness to communicate with school staff regarding this medication.

Wausau School District Seizure Observation Record

Student Name:	**Date of Birth:** **Grade:**
Seizure Date & Time	
Seizure Length *(minutes, seconds)*	
Pre-Seizure Observation *(behaviors, triggering events, activities)*	
Consciousness *(yes, no, altered)*	
Injuries *(describe)*?	
Muscle Tone/Body Movements *(rigid, clenching, limp, fell down, tocking, wandering around, whole body jerking)*	
Extremity Movements *(arm jerking, leg jerking, random movements, specify right/left)*	
Skin Color *(blue, pale, flushed)*	
Eyes *(dilated pupils, turned, rolled up, staring, blinking, closed, specify right/left)*	
Mouth *(drooling, chewing, lip smacking)*	
Sounds *(gagging, talking, throat clearing)*	
Breathing *(normal, labored, stopped, noisy)*	
Incontinent *(urine or stool)*	
Post-Seizure Observation *(confused, tired, headache, speech slurring, etc.)*	
Time until person is fully awake and aware	
Parent/Guardian Notified?	Yes/No: Name(s): Time(s):
EMS Called *(yes/no, time)*?	
Observer(s) Name(s)	