

CHERRY HILL PUBLIC SCHOOLS
SEIZURE ACTION PLAN
Adapted from Epilepsy Foundation

STUDENT INFORMATION:

Student Name: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: Grade:
School Name:	School Year: 20 ____ to 20 ____
Parent/Guardian:	Phone number:
Emergency Contact/Relationship:	Phone number

SEIZURE INFORMATION:

Seizure Type	How Long it Lasts	How Often	What Happens

PROTOCOL FOR SEIZURE DURING SCHOOL: (check all that apply)

<input type="checkbox"/> First aid - STAY. SAFE. SIDE	<input type="checkbox"/> Contact school nurse at:
<input type="checkbox"/> Give rescue medication according to the plan below (nurse only)	<input type="checkbox"/> Call 911 for transport to:
<input type="checkbox"/> Notify parent/emergency contact	<input type="checkbox"/> Other:

FIRST AID FOR ANY SEIZURE:

<input type="checkbox"/> STAY calm, begin TIMING seizure	<input type="checkbox"/> SAFE- Keep airway clear, do NOT put objects in the mouth.
<input type="checkbox"/> SAFE- Remove harmful objects, don't restrain, protect head	<input type="checkbox"/> SIDE - Turn on the side if not awake
<input type="checkbox"/> SAFE- Gently lower to the floor when possible	<input type="checkbox"/> STAY until recovered from the seizure

CALL 911 WHEN:

<input type="checkbox"/> Seizure with loss of consciousness and/or not responding to rescue medication if available
<input type="checkbox"/> Repeated seizures lasting longer than 10 minutes, no recovery between them, not responding to rescue medication if available
<input type="checkbox"/> Change in seizure type, number or pattern
<input type="checkbox"/> Person does not return to usual behavior (i.e. confused for a long period)
<input type="checkbox"/> Difficulty breathing after a seizure
<input type="checkbox"/> Serious injury occurs or suspected, seizure in water
<input type="checkbox"/> Other:

EMERGENCY MEDICATION :

If seizure (cluster, number or length):		
Medication:	Dose:	Route:

INSTRUCTIONS FOR POST SEIZURE CARE:

DAILY SEIZURE MEDICATIONS:

Medication	Dose	Frequency

SPECIAL INSTRUCTIONS:

VNS:
Other:

OTHER INFORMATION:

Triggers:
Important Medical History:
Allergies:
Epilepsy Surgery (type, date, side effects):
Device: <input type="checkbox"/> VNS <input type="checkbox"/> RNS <input type="checkbox"/> DBS Date implanted:
Diet Therapy: <input type="checkbox"/> Ketogenic <input type="checkbox"/> Low Glycemic <input type="checkbox"/> Modified Atkins <input type="checkbox"/> Other (describe)
Special Instructions:

HEALTH CARE CONTACTS:

Epilepsy Provider (print):	Phone:
Primary Care (print):	Phone:
Preferred Hospital (print)	Phone:

SIGNATURES:

<p>I consent to the release of the information contained in this Seizure Action Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I give permission to the school nurse or another qualified healthcare professional to contact my child's healthcare provider. We understand that the Cherry Hill Public School District shall incur no liability as a result of any injury arising from the above Seizure Action Plan. We further acknowledge that we understand that any person who acts in good faith in accordance with the requirements of law shall be immune from any civil or criminal liability arising from actions performed pursuant to this request.</p>

Parent/Guardian Name:	Signature:	Date:
Provider Name: (STAMP)	Signature:	Date: