



Seizure Action Plan

School Year _____ Grade ___ Class 20___

Student Name:		DOB:	School:
Parent/Guardian 1:		Phone:	
Parent/Guardian 2:		Phone:	
Epilepsy Provider:	Phone:	Fax:	
Clinic:		Preferred Hospital:	
Allergies/Other medical conditions:			

Date of last seizure:	Type(s) of seizure:
Description of last seizure:	
Warning signs/triggers:	

Daily Seizure Medication	Strength	Dose	Time	Route	Possible Side Effects
Seizure Rescue Medication	Strength	Dose	Time	Route	Possible Side Effects

Other considerations/directions:	
Start date:	End date:

Parent/Guardian Release/Request for Administration of Medication

●I request that the above medication/treatment be administered to my student as prescribed by the healthcare provider. I release school personnel from liability in the event adverse reactions result from taking the medication(s). ●I understand I must provide medication in the original bottle, properly labeled by the pharmacy with the student's name, date, dosage, time and directions for administration. ●I give permission for the medication(s) to be given by school personnel as delegated by the licensed school nurse. ●I understand and authorize my child's healthcare provider to release or share my child's protected health information regarding this medication and/or medical condition. ●If my student has any remaining medication(s) during or at the end of the school year, I authorize Health Services personnel to send it home with my student. I will notify the Health Office if I prefer to pick it up. All controlled substances will need to be picked up. If medication is left over and not picked up within 2 weeks after expiration or conclusion of the school year, it will be disposed of. ●I will immediately notify Health Services of any change in the medication(s) i.e dose change, medication, discontinued, etc. ●I understand it is my responsibility to notify the transportation company directly of any specific directions for my student's care while riding transportation before or after school.

School Contacts	_____,LSN	_____,HA
Direct Cell #:	_____	Phone #: _____ ext #: _____

Provider Signature: _____ **Date:** _____
Parent Signature: _____ **Date:** _____

Seizure First Aid

How to help someone having a seizure

1

STAY with the person until they are awake and alert after the seizure.

- ✓ Time the seizure
- ✓ Remain calm
- ✓ Check for **medical ID**



2

Keep the person **SAFE**.

- ✓ Move or guide away from **harm**



3

Turn the person onto their **SIDE** if they are not awake and aware.

- ✓ Keep **airway clear**
- ✓ **Loosen tight clothes** around neck
- ✓ Put **something small and soft** under the head



Call
911
if...

- ▶ Seizure lasts longer than 5 minutes
- ▶ Person does not return to their usual state
- ▶ Person is injured, pregnant, or sick
- ▶ Repeated seizures
- ▶ First time seizure
- ▶ Difficulty breathing
- ▶ Seizure occurs in water

Do
NOT

- ✗ Do **NOT** restrain.
- ✗ Do **NOT** put any objects in their mouth.
- ✓ **Rescue medicines can be given** if prescribed by a health care professional

Learn more: [epilepsy.com/firstaid](https://www.epilepsy.com/firstaid)



[epilepsy.com](https://www.epilepsy.com)

24/7 Helpline: 1-800-332-1000

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