



Clayton County Public Schools Seizure Action Plan (IHP)

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Effective Date _____

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name: _____ Date of Birth: _____
Parent/Guardian: _____ Phone: _____ Cell: _____
Treating Physician: _____ Phone: _____
Significant medical history: _____

I understand that it is my responsibility as the parent/guardian of _____ to notify the school nurse/designee of any changes in my child's health condition and/or medication/treatment regimen. I authorize my child's physician and his/her staff to release medical information regarding my child's health condition. I understand that this medical information will only be shared with pertinent school staff.

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

I acknowledge that _____ ☐ Fully ☐ Moderately ☐ No Understanding of his/her epilepsy/seizure disorder.

Can _____ manage his/her epilepsy/seizure disorder? ☐ Yes ☐ No

Physician's Signature _____

Date _____

BASIC FIRST AID: CARE & COMFORT: (Please describe basic first aid procedures.)

Does student need to leave the classroom after a seizure? YES NO

If YES, describe process for returning student to classroom

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol: (Check all that apply and clarify below)

- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____ Notify
- ☐ parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other Support Services _____

A Seizure is generally considered an Emergency when:

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

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication _____

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO
If YES, Describe magnet use _____

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

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____ Reviewed by Supervising Healthcare

Professional: _____ Date: _____