



Seizure Action Plan

Student Information:

Last Name (legal):	First Name (legal):	Date of Birth:	Grade:	School:

Type of Seizures:

Absence – staring and decrease in responsiveness
 Simple partial seizures
 Complex partial seizures
 Generalized tonic-clonic seizures
 Tonic Seizures
 Drop (atonic) seizures
 Other (Specify) _____

Seizure Information:

Date of Last Seizure: _____ Length of Typical Seizure: _____
 Describe Typical Seizure: _____
 Frequency of Seizures: Daily Weekly Monthly Other (Specify) _____
 Possible Triggers: _____
 Student's Response After Seizure: _____

Emergency Response:

A seizure emergency for this student is defined as:	Seizure Emergency Protocol <ul style="list-style-type: none"> • Administer emergency medications as indicated below, for seizures lasting greater than _____ minutes. • Notify parent or emergency contact.
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Medications: include daily and emergency

Medication	Dosages & Time of Day Given	Common Side Effects & Special Instructions

Does child have a Vagus Nerve Stimulator (VNS) Yes No
 Instructions for VNS: _____

First Aid Procedure:

When to call 911:

<input type="checkbox"/> STAY calm, keep calm, begin timing seizure <input type="checkbox"/> Keep me SAFE – remove harmful objects, don't restrain, protect head <input type="checkbox"/> SIDE – turn on side if not awake, keep airway clear, don't put objects in mouth <input type="checkbox"/> STAY until recovered from seizure <input type="checkbox"/> Swipe magnet for VNS <input type="checkbox"/> Give rescue therapy according to SAP <input type="checkbox"/> Notify emergency contact	<input type="checkbox"/> Seizure with loss of consciousness longer than 5 minutes <input type="checkbox"/> Not responding to rescue meds if available after _____ minutes of medication given. <input type="checkbox"/> Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available <input type="checkbox"/> Difficulty breathing after seizure <input type="checkbox"/> Serious injury occurs or suspected, seizure in water <input type="checkbox"/> Other _____
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FIELD TRIPS:

- Send a copy of the Seizure Action Plan.
- If supplied by parents, emergency medication will be sent along on the field trip to be used by 911 personnel or by a staff person who has been trained by the Licensed School Nurse/RN, and delegated to administer the medication.

Physician's Authorization: I authorize the above plan to be followed at school

Physician's Printed Name:	Signature:	Date:

Parent/Guardian Information:

Parent/Guardian #1			Parent/Guardian #2		
Legal Last Name:	Legal First Name:	MI:	Legal Last Name:	Legal First Name:	MI:
Phone #1:	Phone #2:		Phone #1:	Phone #2:	

PARENT /GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

- I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
- I give permission for the medication(s) to be given by school personnel as delegated by the School nurse.
- If my child 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 child. I will notify Health Services if I prefer to pick up the medication(s) at school.
- I give permission for Health Services personnel to communicate, as needed, with school staff about my child's medical condition(s).
- I give permission for Health Services personnel to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) or medical conditions(s) being treated by the medication(s).
- I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to Health Services personnel.
- I release school personnel from liability in the event adverse reactions result from taking the medication(s).
- **Transportation: It is the parent's responsibility to notify the transportation company directly of any specific directions for your child's care while riding transportation during the school day**

NOTE: Medication must be supplied in the original prescription bottle.

Parent/Guardian Signature _____ Date _____

Emergency Response-School Staff:

Health services Assistant(Health office): _____ Licensed School Nurse: _____

Parent/Guardian Authorization for Action Plan: I understand that this action plan may be revoked at any time in writing, and expires in one calendar year. I authorize the above plan to be followed in school.

Printed Name:	Signature:	Date: