# Wentzville School District
# Seizure Action Plan

**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: _____ DOB: _____

Parent/Guardian: _____ Phone: _____Cell:_____

Other Emergency Contact: _____ Phone: _____Cell:_____

Treating Physician: _____ Phone: _____

Significant Medical History: _____

**Seizure Information:**

| Seizure Type | Length | Frequency | Description |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Seizure triggers or warning signs:** _____

**Student's reaction to seizure:**

**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:

**Basic Seizure First Aid**

- √ Stacy Calm & Track Time
- √ Keep Child Safe
- √ Do not restrain
- √ Do not put anything in mouth
- √ Stay with child until fully conscious
- √ Record Seizure in Log

**For Tonic-clonic (grand mal) seizure:**

- √ Protect Head
- √ Keep airway open/watch breathing
- √ Turn child on side

**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 medication as indicated below
- ☐ Other _____

**A seizure is generally considered an emergency when:**

- √ 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 a 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.)**

**Describe any special considerations or precautions here or on back of form:**

Physician Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____