



Lee County School System Seizure Action Plan

Student Name: Date of Birth: Parent/Guardian: Phone #1: Phone #2: Other Emergency Contact: Phone #1: Phone #2: Treating Provider: Phone: Significant Medical History:

SEIZURE INFORMATION

Table with 4 columns: Seizure Type, Length, Frequency, Description

Seizure triggers or warning signs:

Student's response after a seizure:

DAILY MEDICATIONS

(Medications taken on a regular basis to prevent seizure activity)

Table with 3 columns: Medication Name, Dosage, Common Side Effects & Special Instructions

EMERGENCY MEDICATIONS

(Medications prescribed to be given during Yellow or Red Zone)

Table with 3 columns: Medication Name, Dosage, Common Side Effects & Special Instructions

Does the student have a Vagus Nerve Stimulator (VNS)? YES NO

If YES, Describe magnet use:



<p align="center">Green Zone Less than 2 minutes</p>	<p align="center">Yellow Zone 2 to 5 minutes</p>	<p align="center">Red Zone More than 5 minutes or 3 or more seizures in an hour</p>
<ul style="list-style-type: none"> • Begin Seizure First Aid • Closely observe student until recovered from seizure • Notify Parent/Guardian • Return student to class, if appropriate 	<ul style="list-style-type: none"> • Continue Seizure First Aid • Call for help • Prepare to administer prescribed emergency medication • Closely observe student until recovered • Notify Parent/Guardian • Return student to class if no emergency medication administered 	<ul style="list-style-type: none"> • Continue Seizure First Aid • Administer emergency medication as prescribed • Call 911 • Monitor respirations and heart rate, begin CPR if needed • Notify parent/guardian • Parent/guardian will determine if the student should be transported to hospital or go home for rest and observation.

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

Provider Signature: _____ Date: _____

Parent Signature: _____ Date: _____