



THOMAS COUNTY SCHOOLS

Dr. Lisa Williams, Superintendent

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Seizure Action Plan

THE FOLLOWING IS FOR COMPLETION BY PARENT/GUARDIAN:

Student Name _____ D.O.B. _____ Grade Level _____

School _____ First Period Teacher _____

Physician _____ Physician Telephone Number _____

Allergies: _____

Important Medical History/Diagnosis: _____

Emergency Contacts:

#1. Name: _____ Relationship: _____ Phone #: _____

#2. Name: _____ Relationship: _____ Phone #: _____

Description of Seizures:

Seizure Type	Duration (how long do they last)	Frequency (how often)	Describe the seizure

Possible seizure triggers that should be avoided: _____

What does the student's typical postictal or post-seizure phase look like? How long does it typically take them to return to their normal self?

Is there anything else school personnel should know to properly care for the student?

Seizure Action Plan

Student Name: _____ Date: _____

Physician Name: _____

THE FOLLOWING IS FOR COMPLETION BY PHYSICIAN:

Response to seizures while at school (check all boxes that apply):

	Call 911	Call Doctor	Call Parent
Seizure of any type			
Seizure lasting more than 5 minutes			
Repeated seizures longer than 10 minutes, no recovery between			
Seizure not responding to rescue medication			
Difficulty breathing after seizure ends			
Serious injury occurs or seizure in water			
Change in seizure type, pattern, or number			
Other item:			

Is the student on SCHEDULED medication to control seizures? No ___ Yes ___ (Please list below.)

Does the student have RESCUE medication needed at school? No ___ Yes ___ (Please list below.)

Does the Rescue Medication need to be transported with the student on the school bus? No ___ Yes ___

Scheduled Medication	Dosage	Time Given	Route

Rescue Medication	Dosage	Time Given	Route

Please note: all medications must be in a properly labeled and dated container. Medications without prescription labels or that are out of date can not be accepted or administered by School Nurses.

Does the student need any special activity adaptations/protective equipment (e.g., helmet) at school?

No _____ Yes _____ (Please explain below.)

Should the student be restricted from any specific activity (e.g., swimming, horseback riding)?

No _____ Yes _____

(Please explain.) _____

Does the student have a VNS? No _____ Yes _____ Please provide instructions for use: _____

This Seizure Action Plan in its entirety needs to be implemented for the student named above while he/she is at school, attending a school sponsored event, or being transported by school bus or other school transportation.

Physician's Printed Name _____

Physician's Signature _____ Date _____

This Seizure Action Plan needs to be implemented for my child, _____, while he/she is at school, attending a school sponsored event, or being transported by school bus or other school transportation. As the parent, I authorize the exchange of confidential information contained in the record of my child to take place between the school nurse and physician. My signature is an informed consent to share this medical information with school staff on a need to know basis for academic success and emergency planning as determined by the school nurse.

Parent's Printed Name _____

Parent's Signature _____ Date _____

I, the school nurse, have reviewed the Seizure Action Plan for the student listed above.

School Nurse's Printed Name _____

School Nurse's Signature _____ Date _____