

Seizure Action Plan

School Year _____

Student Name: _____ Date of Birth: _____

School: _____ School Phone #: _____ School Fax: _____

Parent/Guardian: _____ Home Phone: _____ Cell: _____

Emergency Contact: _____ Home Phone: _____ Cell: _____

Primary Physician: _____ Phone: _____ Fax: _____

Neurologist: _____ Phone: _____ Fax: _____

Other significant medical history: _____

Seizure triggers or warning signs: _____

Student's response after seizure: _____

Seizure Information				
Seizure Type	Length	Frequency	Description	Last Seizure Date

Daily Seizure Medication			
Medicine Name	Total Daily Amount	Amount of Tablet/Liquid	How Taken –Time & Dose

Seizure Response
First Aid for any Seizure: ✓ STAY calm, begin timing seizure ✓ Keep student SAFE-remove harmful objects, don't restrain, protect head ✓ Put on their SIDE-if not awake, keep airway clear, don't put objects in their mouth ✓ STAY until recovered from seizure ✓ Swipe magnet for VNS, if applicable ✓ Write down what happened
When to call 911: ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available ☐ Seizure with loss of consciousness longer than 10 minutes, no recovery between them, not responding to rescue med if available ☐ Difficulty breathing after seizure ☐ Serious injury occurs or suspected, seizure in water ☐ Parent requests 911 to be called for any seizure ☐ Special instructions for First responders _____
Additional Individual Student Information: ☐ Call 911 for transport to _____ ☐ Contact school nurse to access further actions

Seizure Action Plan

School Year _____

When to call provider first

- *Change in seizure type, number or pattern
- *First time seizure that stops on its' own
- *Person does not return to usual behavior (i.e., confused for a long period)
- *Other: _____

When rescue therapy may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____
Name of Med/Rx _____ How much to give (dose) _____ How Given _____

If seizure (cluster, # or length) _____
Name of Med/Rx _____ How much to give (dose) _____ How Given _____

If seizure (cluster, # or length) _____
Name of Med/Rx _____ How much to give (dose) _____ How Given _____

Post Seizure Care

- ☐ Parent requests notification after each seizure

What type of help is needed (Describe) _____

When can student return to classroom activities? _____

Other Information

- ☐ Epilepsy Surgery (type, date, side effects) _____
- ☐ VNS ☐ RNS ☐ DBS Date Implanted _____ Magnet Location: _____
- ☐ Wait _____ minutes between swipes
- ☐ Give _____ swipes before any emergency medication
- ☐ Special Information not previously disclosed/related _____

TRANSPORTATION SPECIAL CONSIDERATIONS AND PRECAUTIONS

Special considerations, seating arrangements or precautions to be taken by bus personnel:

- ☐ None ☐ Special Needs Bus ☐ Seating _____ ☐ _____

NOTE: Safe administration of Emergency Rectal Medication CANNOT be guaranteed in an occupied moving bus. Therefore, 911 is contacted immediately for any medical emergency. This protocol is in alignment with York County Fire and Life Safety Protocols and the surrounding regions.

Physician Name/ Signature: _____ Date: _____

I give permission for school staff to contact the physician for consultation or exchange of information as needed and for school personnel to follow this plan and provide appropriate medication administration. I understand that if my child receives Diastat before or during school, they may be excluded from school for a minimum of 4 hours of observation before returning to their classroom.

Parent/Guardian Signature: _____ Date: _____

Health Services Personnel Signature: _____ Date: _____

NOTE: This form must be renewed annually or with any change in treatment or medication. The Medication Administration Form must also be completed in addition to the Seizure Action Plan if medication is required at school or school activities.