Deer Valley Unified School District •

SEIZURE EMERGENCY ACTION PLAN

(Confidential Medical Information)

Place Student's Picture Here

2025-2026 School Year

Student Name: _____ **Date of Birth**: _____

Teacher Name: _____ **Grade:** _____

ATTACH COPY OF STUDENT EMERGENCY CARD FOR ADDITIONAL INFORMATION

SEIZURE: a neurological condition with symptoms that vary from a momentary lapse of attention to convulsions

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe action/basic first aid procedures to take during seizure:

Does student need to leave the classroom after a seizure? Yes ☐ No ☐

If YES, describe process for returning student to classroom:

Seizure Emergency

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
- ☐ Administer emergency medications as indicated below
- ☐ Notify doctor
- ☐ Other _____

Basic Seizure First Aid

- Stay 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 seizure:

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

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 is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Original: School Nurse **Copy**: Parents/Teacher(s)/Applicable School Personnel

Continued Reverse Side ➡

Copy: Applicable Departments, e.g., Food Services, Transportation

Continued Reverse Side ➡

Post Seizure Care:

Seizure ↓ 1 minute	Seizure ↓ 5 minutes	Seizure ↑ 5 minutes

Treatment Protocol During School Hours (include daily and emergency medications)

Medication taken? ☐ Yes ☐ No If YES, complete the following:

Medication	Dosage	Time(s)	Route**	Possible Side Effects	Taken At School
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

What **emergency/rescue medications** are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What To Do After Administration

** After 2nd or 3rd seizure, for cluster of seizure, etc.* *** Orally, under tongue, rectally, etc.*

Does student have a **Vagus Nerve Stimulator?** ☐ Yes ☐ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Could this physical impairment substantially limit a major life activity? ☐ **No** ☐ **Yes**

Special instructions from physician (if needed):

Release of information: **The undersigned parent/guardian authorizes the release and/or exchange of medical information between the school nurse and my child's physician named below as it relates to this medical condition. I further authorize the school nurse to distribute copies of this document in accordance with the distribution list indicated on the reverse side of this document to ensure thesafe and proper care of my child while being transported to and from school as well as during school hours. I understand that professional staff will use the medical information given or received and that this information will not be released to any other party not designated herein.**

Physician Name: _____ **Diagnosis:** _____ **ICD-10 Code** _____

Physician Phone Number: _____ _____ _____

Parent/Guardian Signature **Date**

Physician FAX Number: _____ _____ _____

Nurse Signature **Date**