ONTARIO-MONTCLAIR SCHOOL DISTRICT

Health Services

Seizure Action Plan

School Phone # ________________
School Fax # ________________

This student is being treated for a seizure disorder. The information below may assist if a seizure occurs during school hours or at school activities.

Student Name: ____________ **Date of Birth:** ____________ **School:** ____________
Parent/Guardian: ____________ **Home Phone:** ____________ **Cellular:** ____________
Primary Physician: ____________ **Phone:** ____________ **FAX:** ____________
Neurologist: ____________ **Phone:** ____________ **FAX:** ____________

Physician completes form from this point forward.

Significant Medical History: ________________________________

Seizure Information

Seizure Type	Length	Frequency	Description	Last Seizure Date

Seizure triggers or warning signs: ________________________________

Student's response after seizure: ________________________________

Seizure Response – BASIC

- Stay calm and record start of seizure
- Keep child safe but Do NOT restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Document ending time and description of seizure

Tonic-clonic seizure additional response: • Protect child's head • Turn child on side • Keep airway open • Monitor breathing

Additional Individual Student Information:

Parent requests notification after each seizure ☐ Yes ☐ No
Does student need to leave the classroom after a seizure? ☐ Yes ☐ No
If YES, describe process for returning student to classroom: ____________
____

In case of incontinence, parent should provide extra clothing for school so student may return to class as allowed by process above. ☐ Yes ☐ No

Seizure Response – EMERGENCY

- ☐ Call 911 for paramedics
- ☐ Contact school nurse
- ☐ Administer emergency medications if indicated below
- ☐ Notify parents or emergency contact (as listed above)
- ☐ Notify doctor listed above
- ☐ 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 is injured, has diabetes, or is pregnant
Student has a first-time seizure
Student has breathing difficulties
Student has a seizure in water

A "seizure emergency" for this student is additionally defined as: ________________________________

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

* Emergency Medication?	*Medication Name	Dosage and Time of Day Given	Common Side Effects and Special Instructions
☐ Y or ☐ N			
☐ Y or ☐ N			

Does student have a Vagus Nerve Stimulator? ☐ Yes ☐ No, If YES, describe magnet use: ____________
Call 911 if still seizing after ________ VNS swipes. Wait ________ minutes between swipes. Give ________ swipes before any emergency medication.

Special Considerations and Precautions (regarding school activities, sports, trips, helmet use, or bus riding after seizure, etc.)

Describe any special considerations or precautions: ________________________________
____

Physician Name: ____________ ***Physician Signature:*** ____________ ***Date:*** ____________

I give permission for school staff to contact the physician for consultation and exchange of information as needed.

Signature of Parent or Guardian: ____________ ***Date:*** ____________ **Phone Number:** ____________

This form must be renewed annually or with any change in treatment or medication.

The *Medication Administration Form* must be completed in addition to the *Seizure Action Plan* if medication is required at school or school activities.