

**Ohio Department of Health
Seizure Action Plan (SAP)
For a Student with an Active Seizure
Disorder (Epilepsy) Diagnosis**
Per [ORC 3313.7117](#) and [3313.713](#)



School Year:

20____ / 20____

SAP is effective only for the school year in which it is written.

A. STUDENT INFORMATION (This section completed and signed by Parent/Guardian)

Student:	DOB:	Grade:	School:
Parent/Guardian:	Phone:		Email:
Treating Practitioner:	Phone:		Fax:
School Nurse/School Administrator:	School Phone:		Fax:

As parent/guardian of the above-named student, I give permission for my student’s healthcare provider to complete this Seizure Action Plan/Seizure Medication Protocol and share the information with the school nurse/school administrator. I understand the information contained in this plan will be shared with school staff per [ORC 3313.7117](#).

- ✓ I authorize an employee of the school to administer seizure care and prescribed drugs listed in this plan.
- ✓ I understand that additional parent/prescriber signed statements will be necessary if the plan is changed.
- ✓ I also authorize the licensed health care professional to talk with the prescriber or pharmacist to clarify the Seizure Action Plan and/or drug(s) to be given.
- ✓ The Seizure Action Plan must be received by the school nurse, school administrator, or a school employee.
- ✓ I understand that a drug prescribed in this plan shall be provided in the container in which it was dispensed by the prescriber or a licensed pharmacist, to the school nurse or other designated person at the school who is authorized to administer the drug.

Parent/Guardian Name (print):	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:

B. SEIZURE CARE INFORMATION

Seizure Type/Description	Length	Frequency

Seizure triggers or warning signs:

Student specific information:

Does student need to leave the classroom after a seizure? YES NO

If YES, describe process for returning student to classroom:

SPECIAL CONSIDERATIONS:

Bus/Transportation:

Field Trips:

Sports:

Emergency situation such as “Lock Down”:

Other:

Student Name		DOB:	School Year:
SEIZURE CARE INFORMATION (continued) – Marks all behaviors that apply to student			
If you see this:		Do this:	
<input type="checkbox"/> Sudden cry or squeal. <input type="checkbox"/> Loss of bowel or bladder control. <input type="checkbox"/> Staring. <input type="checkbox"/> Rhythmic eye movement. <input type="checkbox"/> Lip smacking. <input type="checkbox"/> Gurgling or grunting noises. <input type="checkbox"/> Falling down. <input type="checkbox"/> Rigidity or stiffness. <input type="checkbox"/> Thrashing or jerking. <input type="checkbox"/> Change in breathing. <input type="checkbox"/> Blue color to lips. <input type="checkbox"/> Froth from mouth. <input type="checkbox"/> Loss of consciousness. <input type="checkbox"/> Other (specify): _____		<input type="checkbox"/> Stay calm and track time. <input type="checkbox"/> Report symptoms and duration to parent. <input type="checkbox"/> Keep student safe. <input type="checkbox"/> Do not restrain. <input type="checkbox"/> Protect head. <input type="checkbox"/> Keep airway open/watch breathing. <input type="checkbox"/> Turn student on side. <input type="checkbox"/> Do not put anything in mouth. <input type="checkbox"/> Do not give fluids or food during or immediately after seizure. <input type="checkbox"/> Stay with student until fully conscious. <input type="checkbox"/> Ensure symptoms resolve before student leaves classroom. <input type="checkbox"/> Administer prescribed seizure rescue medication. <input type="checkbox"/> Swipe VNS magnet. <ul style="list-style-type: none"> ◦ Describe magnet use and location of implanted device on student: _____ <input type="checkbox"/> Other (specify): _____	
Expected behavior after a seizure:		When to CALL 911	
<input type="checkbox"/> Tiredness. <input type="checkbox"/> Weakness. <input type="checkbox"/> Sleeping, difficult to arouse. <input type="checkbox"/> Somewhat confused. <input type="checkbox"/> Regular breathing. <input type="checkbox"/> Other (specify): _____ Follow-Up with: <input type="checkbox"/> Notify school nurse or school administrator. <input type="checkbox"/> Document observations.		<input type="checkbox"/> Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available. <input type="checkbox"/> Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available. <input type="checkbox"/> Difficulty breathing after seizure. <input type="checkbox"/> Serious injury occurs or suspected, seizure is in water. <input type="checkbox"/> Other (specify): _____	
SEIZURE MEDICATION PROTOCOL DURING SCHOOL HOURS (Completed by Treating Practitioner)			
Name of Medication/Dose (how much)		Route (how to give)	When to give (seizure cluster, # or length)
Licensed Healthcare Professional Authorized to Prescribe			
Treating Practitioner Name (print):		Signature:	Authorization Dates: Start Date: _____ Stop Date: _____
Phone Number:		Practice Address:	

Student Name	DOB:	School Year:
C. FOR SCHOOL USE ONLY (Completed by School Nurse or School Administrator).		
EMERGENCY SEIZURE RESCUE MEDICATION and SEIZURE DISORDER CARE		
Designated person(s) trained to give seizure disorder care, seizure medication, and/or use VNS magnet:		
School Employee(s) (specify name)	Dates of Training (Required every 2 years)	
Location of seizure rescue medication (must be locked but accessible) and/or VNS magnet:		
SCHOOL NURSE or SCHOOL ADMINISTRATOR		
Distribution of and training on the Seizure Action Plan (this form) to the school staff who (1) regularly interacts with the student; (2) has legitimate educational interest in the student or is responsible for direct supervision of the student; (3) is responsible for transportation of the student to and from school.		
Specify Names	Date SAP received/trained	
<input type="checkbox"/> Front office/administrative staff:		
<input type="checkbox"/> Teacher(s)/classroom staff:		
<input type="checkbox"/> Transportation:		
<input type="checkbox"/> Other(s):		
Seizure Action Plan (this form) is the responsibility of and maintained in the office of: <input type="checkbox"/> School Nurse and/or <input type="checkbox"/> School Administrator		
School Nurse Signature:	Date:	
School Administrator Signature:	Date:	
ADDITIONAL INFORMATION FOR SCHOOL USE		