

# SEIZURE ACTION PLAN (SAP)



Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

### Protocol for seizure during school (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> First aid – <b>Stay. Safe. Side.</b>     | <input type="checkbox"/> Contact school nurse at _____   |
| <input type="checkbox"/> Give rescue medication as ordered        | <input type="checkbox"/> Call 911 for transport to _____ |
| <input type="checkbox"/> Notify parent/guardian/emergency contact | <input type="checkbox"/> Other _____                     |

### Treatment Plan for Seizure

- **STAY** calm, keep calm, **begin timing seizure**
- Keep me **safe** – remove harmful objects, don't restrain, protect head
- **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- **STAY** until recovered from seizure
- Write down what happens (i.e., behavior, length of seizure activity, and treatment given)
- **Should the seizure last longer than \_\_\_\_\_ minutes, administer emergency medication as indicated below and CALL 911**

**Emergency Seizure Medication – To Be Completed By Physician: All medication orders should be dated on/after July 1<sup>st</sup> for upcoming school year. \***

MEDICATION*	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Student may participate in all sports activities

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

STAMP/LICENSE/ADDRESS: \_\_\_\_\_ Phone: \_\_\_\_\_

### Parent Consent for Management of Seizure at School:

We (I), the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the following specialized physical health care service for Management of Seizures in school be administered to our (my) child. I will:

1. Provide the necessary supplies and equipment
2. Notify the school nurse if there is a change in pupil health status or attending physician
3. Notify the school nurse immediately and provide new consent for any changes in doctor's orders,

I authorize the school nurse to communicate with the physician when necessary.

Parent/Guardian will notify the Guidance Counselor and School Nurse when the student will be participating in school sponsored before or after school activities.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_