For Office Use Only: Grade/Teacher: _____
Location of medication:
Health Room Student Bus Other_____

SEIZURE Emergency Action Plan – Kershaw County School District

Student: _____ DOB:_____

Emergency Contact Name: _____Relationship: _____

Home: _____ Work: _____Cell: _____

Emergency Contact Name: _____Relationship: _____

Home: _____ Work: _____Cell: _____

Preferred Emergency Facility or Hospital: _____

Other Medical Diagnoses:_____

Age when diagnosed with seizures: _____ Date of last seizure: _____

SEIZURE INFORMATION SECTION TO BE COMPLETED BY THE PARENT/GUARDIAN:

Seizure Type	What Happens?	How long does it last?	How Often?

Seizure Triggers (please list all triggers below)

_____

_____

Seizure Medications	Dosage	Time/Frequency

Other Seizure Treatments:

Device Type:_____Model:_____ Serial #:_____ Date Implanted:_____

Dietary Therapy: _____ Date Begun:_____

Activity and Diet Restrictions:

Does your child have any restrictions relating to activities or diet at school? □ NO □ YES*

Please explain_____

*(*A physician's note is required for any PE/Activity restrictions or special diet)*

SEIZURE TREATMENT SECTION TO BE COMPLETED BY MEDICAL PROVIDER:

SEIZURE FIRST AID	CALL 911 OR SEEK EMERGENCY MEDICAL ATTENTION IF:
• Keep calm, provide reassurance, remove bystanders. • Keep airway clear, turn on side if possible, nothing in mouth. • Keep safe, remove objects, do not restrain. • Time, observe, record what happens. • Stay with person until recovered from seizure. • Home:_____ or • Return To Learn:_____	• Generalized seizure longer than 5 minutes (or time specified by medical provider). • Two or more seizures without recovering between seizures. • "As needed" treatments don't work. • Emergency medications given as needed. • Injury occurs or is suspected, or seizure occurs in water. • Breathing, heart rate or behavior doesn't return to normal. • Other : _____

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Health Room Student Bus Other_____

SEIZURE Emergency Action Plan – Kershaw County School District

Student: _____ DOB:_____

WHEN SEIZURES REQUIRE ADDITIONAL HELP:		
Type of Emergency (long, clusters or repeated events)	**Description**	**What To Do**

AS NEEDED TREATMENTS:			
Name	**Amount to Give**	**How to give**	**When to give**

APPROVALS:

HEALTH CARE PROVIDER SIGNATURE: _____ **Phone**: _____ **Date**:_____

SCHOOL NURSE SIGNATURE: _____ **Phone**: _____ **Date**:_____

By signing this document, the parent/guardian and/or the student authorize sharing this information with school personnel who have a legitimate need for knowledge of the information.

PARENT SIGNATURE: _____ **Phone**: _____ **Date**:_____

Copies of this plan provided to: ☐ *Teachers* ☐ *Phys Ed/Coach* ☐ *Principal* ☐ *Main Office* ☐ *Bus Driver* ☐ *SEAGUL* ☐

*Other:*_____

DATE	***NOTES***

For Office Use Only: Grade/Teacher: _____
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Health Room Student Bus Other_____

SEIZURE Emergency Action Plan – Kershaw County School District

Student: _____ DOB:_____
