



# SEIZURE Emergency Action Plan

Westlake Academy Health Services

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Teacher/Grade: \_\_\_\_\_

Emergency Contact #1: \_\_\_\_\_ Preferred Contact #: \_\_\_\_\_  
 Emergency Contact #2: \_\_\_\_\_ Preferred Contact #: \_\_\_\_\_  
 Physician Treating Seizures: \_\_\_\_\_ Preferred Contact #: \_\_\_\_\_  
 Preferred Hospital: \_\_\_\_\_

Diagnosis/Condition: **SEIZURE DISORDER**

Type of Seizures: \_\_\_\_\_

Date of Last Seizure: \_\_\_\_\_

**PLEASE CHECK THE STUDENT'S SIGNS AND SYMPTOMS:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Aimless wandering    | <input type="checkbox"/> Twitching/Jerking of body parts             |
| <input type="checkbox"/> Falling down          | <input type="checkbox"/> Fluttering eyelids   | <input type="checkbox"/> Loss of Control (bladder, bowels, drooling) |
| <input type="checkbox"/> Muscle stiffness      | <input type="checkbox"/> Blank stare          | <input type="checkbox"/> Rhythmic convulsions                        |
| <input type="checkbox"/> Confusion             | <input type="checkbox"/> Purposeless activity | <input type="checkbox"/> Other: _____                                |
| <input type="checkbox"/> Repetitive movement   |   |  |

**PLEASE CHECK ANY TRIGGERS FOR STUDENT'S SEIZURE:**

- |   |                                      |                                  |                                       |
|---|--------------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Bright light/strobe    | <input type="checkbox"/> Stress      | <input type="checkbox"/> Fever   | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Temperature (hot/cold) | <input type="checkbox"/> Loud Noises | <input type="checkbox"/> Fatigue |                                       |
|   |                                      | <input type="checkbox"/> Hunger  |                                       |

**ACTION IF STUDENT HAS A SEIZURE AT SCHOOL:**

- Rest  
 Call parent  
 Call 911 when \_\_\_\_\_

911 will always be called if seizure lasts longer than 5 minute AND/OR

- If student has repeated seizures
- If student has trouble breathing
- If student cannot be aroused after seizure
- If student is pregnant, diabetic, or has no known seizure history

Administer following emergency medication(s): (additional form(s) required for medications)

Medication Name	Route	Dosage	Frequency

**Vagal Nerve Stimulator** (Special Procedure Form is required)

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

DIAGNOSIS/CONDITION: SEIZURES TYPE OF SEIZURE: \_\_\_\_\_

**Additional Information:**

**EMERGENCY INTERVENTION: (ADDITIONAL FORMS REQUIRED)**

<u>Emergency Medication</u>	<u>Diastat</u>	<u>Vagal Nerve Stimulation</u>
Medication Name/ Location:	Diastat Location:	Magnet Location:
Trained staff/location:	Trained staff/location:	Trained staff/location:
Trained staff/location:	Trained staff/location:	Trained staff/location:
Buddy Nurse/location:	Buddy Nurse/location:	Buddy Nurse/location:
Other:	Other:	Other:

**Acknowledged and Received By:**

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Registered Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Licensed Vocational Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_