Georgia Cyber Academy
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SEIZURE MEDICAL ACTION PLAN

Student Information		
Student's Name:	Date of Birth:	Grade:
Allergies:		
Contact Information		
Mother's Name:	Home #:	Cell #:
Father's Name:	Home #:	Cell #:
Home Address:	City/State:	Zip Code:
Emergency Contact/Relationship:	Home #:	Cell #:
Primary Care Physician/Pediatrician:	Phone #:	Fax #:
Endocrinologist:	Phone #:	Fax #:
I understand that it is my responsibility as the parent/guardian of _____ to notify the 504 Coordinator/school personnel of any changes in my child's health condition and/or medication/treatment regimen. I authorize my child's physician and his/her staff to release the following information regarding my child's health condition. I understand that this health information will **only** be shared with pertinent school staff.		
Parent/Guardian Signature:	Date:	

Seizure Information			
Seizure Type	**How Long it Lasts**	**How Often**	**What Happens**

Protocol for seizure during school (check all that apply)
☐ First Aid – **Stay**, **Safe**, **Side** ☐ Give rescue therapy according to SAP ☐ Notify parent/guardian/emergency contact. ☐ Call 911 for transport to hospital ☐ Other
First aid for any seizure
☐ **STAY** calm, keep calm, **begin timing seizure** ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect the head ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth ☐ **STAY** until recovered from the seizure ☐ Swipe magnet for VNS ☐ Write down what happens ☐ Other _____
When to call 911
• Seizure with loss of consciousness longer than 5 minutes, not responding to rescue meds if available. • Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue meds if available. • Difficulty breathing after seizure. • Serious injury occurs or suspected, seizure in water.
When to call your provider first
• Change in seizure type, number, or pattern. • Person does not return to usual behavior (i.e., confused for a long period). • First time seizure that stops on its own. • Other medical problems or pregnancy need to be checked.
When rescue therapy may be needed
When and what to do:
If seizure (cluster, # or length)

Name of Med/Rx	How much to give/dose:

How to give:	
If seizure (cluster, # or length)	
Name of Med/Rx	How much to give/dose:
How to give:	
If seizure (cluster, # or length)	
Name of Med/Rx	How much to give/dose:
How to give:	

Care after Seizure

What type of help is needed?

When is the student able to resume usual activity?

Special Instructions

First Responders:

Emergency Department:

Daily Seizure Medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	Time of each dose and how much

Other Information

Triggers:

Important Medical History:
Epilepsy Surgery: (type, date, side effects)
Device: ☐ VNS ☐ RNS ☐ DBS Data Implanted
Diet Therapy: ☐ Ketogenic ☐ Low Glycemic ☐ Modified Akins ☐ Other (describe)
How will this illness impact school attendance? :
Special Instructions:

Health Care Contacts	
Epilepsy Provider:	Phone #:
Primary Care Provider:	Phone #:
Preferred Hospital:	Phone #:
Pharmacy:	Phone #:
Parent/Guardian signature indicates acknowledgement and release for sharing medical information between our student's physician and other health care providers and authorizing the designated school nurse to share medical information with other school employees as necessary.	
Parent/Guardian Signature:	Date:
Provider Signature:	Date