

Pine Grove Area School District

SCHOOL HEALTH SERVICES

2026-2027 School Year

Seizure Action Plan

Name of Student

Date of Birth

Medical Problems

Food Allergies

Medication Allergies

Seizure Information

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>

Date of last seizure

Seizure triggers / warning signs

Student's reaction to seizure

Special considerations / Safety precautions (regarding school activities, sports, trips, etc.)

Seizure First Aid

- Time the seizure
- Keep student safe
- Protect and cushion head
- Remove glasses
- Loosen tight clothing around neck
- Turn student on side
- Do not restrain student or put anything in mouth
- Stay with student until fully conscious and School Nurse arrives
- Document seizure on Epilepsy Foundation Seizure Observation Record
- Notify Parent/Guardian as listed on Student Update form (copy attached)
- Other instructions

Emergency Treatment

A seizure emergency for this student is defined as: (please check all that apply)

- ☐ Seizure lasts longer than ____ minutes ☐ Student is injured
- ☐ Student has difficulty breathing ☐ Any seizure this student has should be treated as an emergency
- ☐ Other

If this student has a seizure emergency, do the following:

- Call 911 for transport to nearest Emergency Room or
- Administer emergency medication
- Other instructions

Physician's Signature

Date

Physician's Name Printed

Physician's Phone Number

Signature of Parent/Guardian

Date



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Medication Order

It is this school district's policy to request that medications be given before or after school hours. When this is not possible, prior to receiving the medication (prescription or non-prescription) at school, each student must provide the school nurse with a Medication Order signed by a licensed prescriber and the student's parent/guardian. All medications must be in the original container. This form is valid only for the current school year.

Name of Student

Date of Birth

Medical Problems

Allergies

Name of Medication

Dosage

Route

Diagnosis / Reason for Taking

Frequency / Time of Administration

Discontinuation Date

Specific Directions

☐ Student may carry and self-administer EpiPen

☐ Student may carry and self-administer inhaler

Additional Information (Serious reactions, side effects, contraindications, etc.)

Other Medications Currently Taking

Licensed Prescriber's Signature

Date

Licensed Prescriber's Name Printed

Licensed Prescriber's Phone Number

I give permission for the above medication to be given to my child during school hours. I understand that the medication will be given according to my child's licensed prescriber's directions. I do hereby release, discharge, and hold harmless the Pine Grove Area School District, its agents and its employees from any and all liability and claim whatsoever for the administration of the above medication to the above named child.

Signature of Parent/Guardian

Date

Seizure Observation Record

Name:				
Date & Time				
Seizure Length				
Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)				
Conscious (yes/no/altered)				
Injuries (briefly describe)				
Muscle Tone/Body Movements	Rigid/clenching			
	Limp			
	Fell down			
	Rocking			
	Wandering around			
	Whole body jerking			
Extremity Movements	(R) arm jerking			
	(L) arm jerking			
	(R) leg jerking			
	(L) leg jerking			
	Random Movement			
Color	Bluish			
	Pale			
	Flushed			
Eyes	Pupils dilated			
	Turned (R or L)			
	Rolled up			
	Staring or blinking (clarify)			
	Closed			
Mouth	Salivating			
	Chewing			
	Lip smacking			
Verbal Sounds (gagging, talking, throat clearing, etc.)				
Breathing (normal, labored, stopped, noisy, etc.)				
Incontinent (urine or feces)				
Post-Seizure Observation	Confused			
	Sleepy/tired			
	Headache			
	Speech slurring			
	Other			
Length to Orientation				
Parents Notified? (time of call)				
EMS Called? (call time & arrival time)				

Please put additional notes on back as necessary.