MCS-241
5/2026

Mason City Schools
Seizure Action Plan

(Per ORC 3313.7117 and 3313.713)

Student Information **School Year_____**

Student Name:		Date of Birth
Grade:	Teacher/Team:	Student ID#
Bus/Transportation:	Student Diagnosis:	

Seizure Care Information

Seizure Type Description:	Length	Frequency
Seizure Warning Signs:		
Emergency Medication	Dose:	Route:
Medications Given at Home:		
Student has ***signed permission from physician*** to self carry medication: Yes_____No_____ Student has ***signed permission from physician*** to self administer medication: Yes_____No_____**("Yes" indicates student has been instructed in proper use, expected result and possible side effects of emergency medication)**		
When to give (Seizure Cluster, #, or length):		
Is medication carried on the bus? Yes_____No_____(Must have permission from physician) Does student have a bus aide? Yes_____No_____Date bus aid trained to give emergency medications_____		
Action to take in the event the drug does not prevent the onset of the seizure or alleviate symptoms of a seizure:		
Date of last seizure:	Medication Given:	
Physician Name:	Phone:	

Seizure Care Information

Onset of Seizure:(adult first responder) Note the time the seizure started, turn the student on their side if possible in case of vomiting, observe breathing, and make sure the airway is open, request another adult to contact the building nurse, and clear the area of other students.
Building Nurse Response: Review seizure occurrence with the first responder, verify physician orders for administration of emergency medication if applicable. Phone 911 if emergency medication is administered. Ensure the parent, administrator, and Building officer have been notified of the district 911 call.
Emergency Response (911) is appropriate when: Seizure duration is longer than the physician's medication orders, repetitive or clustered seizures occur in an unconscious person, no known history of seizure disorder, seizure is secondary to an injury or other medical condition, or breathing impairment accompanies seizure activity.

Parent Information/Permissions

As parent/guardian of the above-named student, I give permission for the nurse/clinic to contact Healthcare providers regarding my child's healthcare related to the seizure action plan. I understand the information contained in this plan will be shared with school staff per ORC 3313.7117. I also understand that this plan is effective only for the school year in which it is written.
Parent Signature_____Date_____