School Seizure Action Plan

(To be completed by a licensed practitioner)

Student's Name: _____ Date of Birth: _____ FCS Student Number: _____

Diagnosis: _____ ICD Code: _____Date form Completed: _____

SEIZURE INFORMATION:

Seizure Type	Known Triggers/Warning Signs	Typical Symptoms	Typical Length	Frequency	Response after Seizure

Name of Implanted Device (if applicable): _____ Date Implanted: _____

Device Special Instructions: _____

Daily Preventative Seizure Medications Administered at Home:

Name of Medication: _____ Dose: _____ Frequency: _____

Name of Medication: _____ Dose: _____ Frequency: _____

BASIC SEIZURE FIRST AID

- ✓ **Stay:** Remain calm, time the seizure and stay with the student until fully recovered.
- ✓ **Safe:** Protect from injury, remove hazards, support head, and do not restrain.
- ✓ **Side:** Turn on side, if possible, do not place anything in the mouth and monitor breathing and skin color.

EMERGENCY SEIZURE ADMINISTRATION DETAILS

Administer Emergency/Rescue Medication For:

- Seizure lasting longer than _____ minutes.
- Repeated/cluster seizures:

  _____ seizures within _____ minutes.

Emergency/Rescue Medication:

_____

Name of Medication/Dose/Route

EMERGENCY SEIZURE RESPONSE

- Administer emergency/rescue medication as prescribed
- Call 911 / Activate EMS
- Notify parent/guardian
- Monitor breathing and responsiveness
- Stay with student until EMS arrives

Per FCS guidelines if emergency medication is administered, 911/EMS will be activated.

_____
Licensed Practitioner Name (PRINT)

_____
Licensed Practitioner Signature & Credentials

_____
Date

Licensed Practitioner Office Stamp:

_____
Parent Name (PRINT)

_____
Parent Signature

_____
Date

By signing above, I authorize Forsyth County School employees to contact my child's healthcare providers and/or pharmacy to obtain medical information related to my child's diagnosis, medications, treatments or any additional care required.