Carbon Lehigh Intermediate Unit #21

SEIZURE PROTOCOL FORM

This form must be completed by a licensed healthcare provider.

Student Name: _____ **DOB:** _____

SEIZURE INFORMATION & HISTORY

Type/ Description:

Duration:

Frequency:

Triggers:

Does student have a Vagus Nerve Stimulator? YES ☐ NO ☐

EMERGENCY MANAGEMENT (Medication, VNS Magnet, Etc.):

SUPPORT & RESPONSE BY CLASSROOM STAFF:

- Contact School Nurse (Call 911 immediately if no nurse available)
- Stay calm and stay with the student
- Keep student safe and remove harmful objects
- Turn student on their side to support the airway
- Do not put anything in their mouth or restrict movement
- Note seizure activity and time the seizure from start to finish

***If medication is prescribed, a Medication Administration Authorization Form is required.**

Licensed Provider Authorization:

Provider Name: _____ Date: _____

Provider Signature: _____

Parent/Guardian Authorization:

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____