



**Brecksville-
Broadview Heights
City School District**

Brecksville-Broadview Heights City Schools Board of Education Office

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Treasurer/CFO

Seizure Action Plan

Student _____ Birth Date _____ School Year _____ Grade _____

Type of Seizure

Please describe the seizures (i.e. staring, repetitive movements, side of the body, rhythmic movements)

List triggers or warning signs: _____

Seizure typically lasts _____ minutes and child returns to baseline in _____ minutes.

Seizure emergency protocol:

____ Diazepam rectal gel _____ mg rectally PRN for seizure > _____ minutes OR for _____ or more seizures in _____ hours. Following administration of Diazepam rectal gel, call parents to pick up child.

____ Use Vagal Nerve Stimulator (VNS) for _____

____ Other _____

Call 911 if:

____ Seizure does not stop by itself or with treatment within _____ minutes.

____ Child does not start waking up within _____ minutes after seizure (no Diazepam given).

____ Child does not start waking up within _____ minutes after seizure (after Diazepam).

____ Always call 911 if child has a seizure.

Following a seizure:

____ Child should rest in clinic until _____.

____ Child may return to class when _____.

____ Notify parents immediately 1. # _____ 2. # _____

____ Notify the physician Name _____ Phone _____

____ Other: Name _____ Phone _____

List any restrictions/safety precautions regarding school activities, sports, field trips (completed by physician). _____

Parent Signature _____ Date _____

Physician Signature _____ Date _____

Nurse Signature _____ Date _____