

## Seizure Action Plan

School Phone # \_\_\_\_\_  
School Fax # \_\_\_\_\_

This student is being treated for a seizure disorder. The information below may assist if a seizure occurs during school hours or at school activities.

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **School:** \_\_\_\_\_  
**Parent/Guardian:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_ **Cellular:** \_\_\_\_\_  
**Primary Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **FAX:** \_\_\_\_\_  
**Neurologist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**Physician completes form from this point forward.**

**Significant Medical History:** \_\_\_\_\_

Seizure Information				
Seizure Type	Length	Frequency	Description	Last Seizure Date

Seizure triggers or warning signs: \_\_\_\_\_

Student's response after seizure: \_\_\_\_\_

Seizure Response – BASIC	Additional Individual Student Information:
<ul style="list-style-type: none"> <li>▪ Stay calm and record start of seizure</li> <li>▪ Keep child safe but Do NOT restrain</li> <li>▪ Do not put anything in mouth</li> <li>▪ Stay with child until fully conscious</li> <li>▪ Document ending time and description of seizure</li> </ul> <p><b>Tonic-clonic seizure additional response:</b> • Protect child's head • Turn child on side • Keep airway open • Monitor breathing</p>	<p>Parent requests notification after each seizure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does student need to leave the classroom after a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, describe process for returning student to classroom: _____</p> <p>_____</p> <p>In case of incontinence, parent should provide extra clothing for school so student may return to class as allowed by process above. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Seizure Response – EMERGENCY	A Seizure is Generally Considered an Emergency When:
<ul style="list-style-type: none"> <li><input type="checkbox"/> Call 911 for paramedics</li> <li><input type="checkbox"/> Contact school nurse</li> <li><input type="checkbox"/> Administer emergency medications if indicated below</li> <li><input type="checkbox"/> Notify parents or emergency contact (as listed above)</li> <li><input type="checkbox"/> Notify doctor listed above</li> <li><input type="checkbox"/> Other: _____</li> </ul>	<ul style="list-style-type: none"> <li>Convulsive (tonic-clonic) seizure lasts longer than 5 minutes</li> <li>Student has repeated seizures without regaining consciousness</li> <li>Student is injured, has diabetes, or is pregnant</li> <li>Student has a first-time seizure</li> <li>Student has breathing difficulties</li> <li>Student has a seizure in water</li> </ul>

A "seizure emergency" for this student is additionally defined as: \_\_\_\_\_

Treatment Protocol During School Hours or School Activities (include daily and emergency medications*)			
* Emergency Medication?	*Medication Name	Dosage and Time of Day Given	Common Side Effects and Special Instructions
<input type="checkbox"/> Y or <input type="checkbox"/> N			
<input type="checkbox"/> Y or <input type="checkbox"/> N			

Does student have a Vagus Nerve Stimulator?  Yes  No, If YES, describe magnet use: \_\_\_\_\_  
 Call 911 if still seizing after \_\_\_\_\_ VNS swipes. Wait \_\_\_\_\_ minutes between swipes. Give \_\_\_\_\_ swipes before any emergency medication.

**Special Considerations and Precautions (regarding school activities, sports, trips, helmet use, or bus riding after seizure, etc.)**

Describe any special considerations or precautions: \_\_\_\_\_  
 \_\_\_\_\_

Physician Name: _____	Physician Signature: _____	Date: _____
I give permission for school staff to contact the physician for consultation and exchange of information as needed.		
Signature of Parent or Guardian: _____	Date: _____	Phone Number: _____

*This form must be renewed annually or with any change in treatment or medication.*

The Medication Administration Form must be completed in addition to the Seizure Action Plan if medication is required at school or school activities.

\* Medication Administration Form Required