



# SEIZURE ACTION PLAN

Effective Date \_\_\_\_\_

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_  
Treating Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Significant medical history: \_\_\_\_\_

### SEIZURE INFORMATION:

Seizure Type	Average length	Description

Average frequency: \_\_\_\_\_  
Seizure triggers or warning signs: \_\_\_\_\_  
Student's reaction to seizure: \_\_\_\_\_

### BASIC FIRST AID: CARE & COMFORT: (Please describe basic first aid procedures)

Does student need to leave the classroom after a seizure? YES NO  
If YES, describe process for returning student to classroom \_\_\_\_\_

### EMERGENCY RESPONSE:

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

✓ Seizure Emergency Protocol: (Check all that apply and clarify below)

- Contact school nurse at x1323/1523
- Call 911 for transport to FAHC
- Notify parent or emergency contact
- Notify doctor
- Administer emergency medications as indicated below
- Other \_\_\_\_\_

<p><b>Basic Seizure First Aid:</b></p> <ul style="list-style-type: none"> <li>✓ Stay calm &amp; track time</li> <li>✓ Keep child safe</li> <li>✓ Do not restrain</li> <li>✓ Do not put anything in mouth</li> <li>✓ Stay with child until fully conscious</li> <li>✓ Record seizure in log</li> </ul> <p>For tonic-clonic (grand mal) seizure:</p> <ul style="list-style-type: none"> <li>✓ Protect head</li> </ul> <p>A seizure is generally considered an emergency when:</p> <ul style="list-style-type: none"> <li>✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes</li> <li>✓ Student has repeated seizures without regaining consciousness</li> <li>✓ Student has a first time seizure</li> <li>✓ Student is injured or has diabetes</li> <li>✓ Student has breathing difficulties</li> </ul>
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### TREATMENT PROTOCOL DURING SCHOOL HOURS:

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions
Emergency/Rescue Medication		

Does student have a Vagus Nerve Stimulator (VNS)? YES NO  
If YES, Describe magnet use \_\_\_\_\_

### SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: (regarding school activities, sports, trips, etc.)

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_