SEIZURE ACTION PLAN

Student's Name:_____ Date of Birth:_____
School:_____ Teacher:_____
Treating Physician:_____ Physician Phone: _____
Significant medical history:_____

EMERGENCY CONTACT INFORMATION:

Name	*Relationship*	*Phone # 1*	*Phone # 2*
1.			
2.			

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description (what does it look like?)*

Seizure triggers or warning signs:_____

Student's reaction to seizure:_____

Will your student have any special activity adaptations/protective equipment (e.g. helmet) at school? NO / YES

If yes, explain:_____

Is the student allowed to participate in physical education and other school trips and activities? NO / YES

Explain/give details:_____

Does student need to leave the classroom after a seizure? NO / YES

Describe process for returning to classroom:_____

_____

A Seizure is generally considered an Emergency when:

- ✓✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓✓ Student has repeated seizures without regaining consciousness
- ✓✓ Student has a first time seizure
- ✓✓ Student is injured or has diabetes
- ✓✓ Student has breathing difficulties
- ✓✓ Student has a seizure in water

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_____
- ☐ Call 911 for transport to_____
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ In absence of nurse or trained volunteer call 911 at onset of seizure
- ☐ Other_____

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure information

For Tonic-Clonic Seizure

- Protect head
- Keep airway open/watch breathing
- Turn child on side

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

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

Emergency Medication	Dosage/Route	When to use	Can it be repeated (if yes, when)

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO
If YES, Describe magnet use_____

Physician Signature:_____ **Date:**_____

Parent Signature:_____ **Date:**_____