

SEIZURE ACTION PLAN

Student's Name: _____ Date of Birth: _____ Grade: _____
 School: _____ Phone #: _____ Fax #: _____

Physician to Complete:

SEIZURE INFORMATION:

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Student's response after a seizure: _____

BASIC FIRST AID: CARE & COMFORT

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

If YES, describe process for returning student to class _____

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as: _____

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

- Call 911 for transport to _____
- Notify parent or emergency contact
- Notify doctor
- Administer emergency medications as indicated below
- 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 in log
- For tonic-clonic (grand mal) seizure:**
- ✓ Protect head
 - ✓ Keep airway open/watch breathing
 - ✓ Turn child on side

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

TREATMENT PROTOCOL DURING SCHOOL HOURS:

include daily and emergency medications)

Medication	Route	Dosage	Frequency

Does student have a **Vagus Nerve Stimulator (VNS)**? YES* NO **If YES, Please complete SPHCS Physician's Authorization.*

Special Considerations and Safety Precautions: _____

Physician's Name (print): _____ **Signature:** _____ **Date:** _____
Office Telephone #: _____ **Office Fax #:** _____

I authorize the school nurse, or other appropriately assigned school staff, to administer the medication/perform the procedure, as prescribed here in by the authorized health care provider. I will notify the school immediately and submit a new form, if there are any changes in the medication, procedure or the prescribing physician. I understand that school health staff are obliged by law to clarify issues associated with this order with the prescribing provider as necessary.

Parent/Guardian Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____