SEIZURE ACTION PLAN

Student's Name:_____ Date of Birth:_____

School: _____ Teacher: _____

Treating Physician:_____ Phone: _____

Significant medical history:_____

EMERGENCY CONTACT INFORMATION:

Name	*Relationship*	*Home #*	*Work #*	*Cell #*
1.				
2.				
3.				

SEIZURE INFORMATION:

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

Seizure triggers or warning signs:_____

Student's reaction to seizure:_____

Does the student need 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

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
- ☐ Other_____

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)

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_____

Physician Signature:_____ **Date:**_____

- ❑ **I want this plan implemented for my child, _____, in school. I hereby give my permission for exchange of confidential information contained in the record of my child between the nurse and physician and my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.**

Parent Signature:_____ **Date:**_____