Seizure Action Plan

with Emergency Seizure Care Instructions

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's First Name		Student's Last Name		Date of Birth (Mo/Da/Year)	

Parent/Guardian Name	Tel (Home)	Tel (work)	Tel (cell)

Other Emergency Contact	Tel (Home)	Tel (work)	Tel (cell)

Child's Neurologist or Treating Physician	Tel Number(s)	Email

Seizure Information

What types of seizures does your child have? Describe seizure symptoms in more detail below.	

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs?	
Student's response after a seizure?	

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Basic Seizure First Aid:
- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log
- X Do not restrain
- X Do not put anything in mouth

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open, watch breathing
- ✓ Turn child on side

Does student need to leave the classroom after a seizure?	**NO**	**YES**	
If YES, describe process for returning student to the 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 91 for transport to: _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ 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 diabetic
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

Treatment Protocol During School Hours

What medication(s) does your child take?			
Medication	Dosage	Time of day given	Common Side Effects & Special Instructions

Does your child have a Vagus Nerve Stimulator?	**NO**	**YES**	If YES, please describe magnet use:

SPECIAL CONSIDERATIONS AND PRECAUTIONS (regarding school activities, sports, trips, etc)

Describe any special considerations or precautions:

EMERGENCY SEIZURE CARE INSTRUCTIONS

Name and purpose of the prescribed emergency anti-seizure medication:			
Emergency Medication	**Dosage**	**Administration Instructions (timing* & method**)**	**The frequency of administration**

After 2nd or 3rd seizure, for cluster of seizure, etc.* * Orally, under tongue, rectally, etc.*

When should emergency anti-seizure medication be administered?

Describe in detail the seizure symptoms, including frequency, type, and length of seizures that identify when the administration of an emergency anti-seizure medication becomes necessary.	

The circumstances under which the medication may be administered:	
Any potential adverse responses by the student and recommended actions and when to call 911:	
A protocol for observing the student after a seizure:	
Who should be contacted to continue observation plan?	

Physician Name	Physician Signature:	Date

Parent/Guardian Name	Parent/Guardian Signature:	Date