

# 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	Phone _____ Cell _____
Other Emergency Contact	Phone _____ Cell _____
Treating Physician	Phone _____

Significant Medical History \_\_\_\_\_

## Seizure Information

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: \_\_\_\_\_

Does student need to leave the classroom after a seizure?  Yes  No

If YES, describe process for returning student to classroom: \_\_\_\_\_

### 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 seizure:

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

### 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
- Administer emergency medications as indicated below
- Notify doctor
- Other \_\_\_\_\_

#### A seizure is generally considered an emergency when:

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

### Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator**?  Yes  No If YES, describe magnet use: \_\_\_\_\_

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**Special Considerations and Precautions (regarding school activities, sports, trips, etc.)**

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Describe any special considerations or precautions:

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

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_