

SEIZURE ACTION PLAN

School _____ Start Date _____ End Date _____

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student _____ Birthdate _____ Grade/Rm. _____

Mother/Guardian _____ Home Tel _____

Cell _____ Work Tel _____

Father/Guardian _____ Home Tel _____

Cell _____ Work Tel _____

Treating Physician _____ Tel _____

Significant Medical History _____

Allergies _____

Triggers or warning signs _____

SEIZURE EMERGENCY PROTOCOL

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

- Seizure lasting > _____ minutes
- _____ or more Seizures in _____ hour(s)
- Other _____

SEIZURE EMERGENCY PROTOCOL: (CHECK ALL THAT APPLY AND CLARIFY BELOW)

- CONTACT NURSE/CLINIC STAFF AT _____
- Call 911 for transport to _____
- Notify parent or emergency contact
- Notify doctor
- Administer emergency medications as indicated below
- Other _____

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

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

Emergency Medication/ Instructions: _____

Call 911 if

- Seizure does not stop within _____ minutes of giving Emergency medication
- Child does not start waking up within _____ minutes after seizure stops (NO Emergency medication given)
- Child does not start waking up within _____ minutes after seizure stops (AFTER Emergency medication is given)
- Seizure does not stop by itself or with VNS within _____ minutes

Following a seizure

- Child should rest in clinic.
- Child may return to class (specify time frame _____)
- Notify parent immediately.
- Send a copy of the seizure record home with child for parents.
- Notify physician.
- Other _____

Seizure Information - Student may experience some or all of the listed symptoms during a specific seizure.

<i>Seizure Type(s)</i>	<i>Description</i>	
<input type="checkbox"/> Absence	<ul style="list-style-type: none"> •Staring •Eye blinking 	<ul style="list-style-type: none"> •Loss of awareness •Other _____
<input type="checkbox"/> Simple partial	<ul style="list-style-type: none"> •Remains conscious •Distorted sense of smell, hearing, sight 	<ul style="list-style-type: none"> •Involuntary rhythmic jerking/twitching on one side •Other _____
<input type="checkbox"/> Complex partial	<ul style="list-style-type: none"> •Confusion •Not fully responsive/unresponsive 	<ul style="list-style-type: none"> •May appear fearful •Purposeless, repetitive movements •Other _____
<input type="checkbox"/> Generalized tonic-clonic	<ul style="list-style-type: none"> •Convulsions •Stiffening •Breathing may be shallow •Lips or skin may have blush color 	<ul style="list-style-type: none"> •Unconsciousness •Confusion, weariness, or belligerence when seizure ends •Other _____

Seizure usually lasts _____ minutes and returns to baseline in _____ minutes.

Triggers or warning signs _____

Call parents under the following circumstances

1. _____
2. _____

Basic Seizure First Aid
<ul style="list-style-type: none"> • 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:
<ul style="list-style-type: none"> • Protect head • Keep airway open/watch breathing • Turn child on side

A Seizure is generally considered an EMERGENCY when
<ul style="list-style-type: none"> • 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

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

Signatures

Parent/Guardian Signature

Date

Physician Signature

Date