

# 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 _____	Teacher _____	Grade _____
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: \_\_\_\_\_  
\*\*\*A completed Authorization for Medication form must be attached for medication at school\*\*\*

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

Describe any special considerations or precautions:  
\_\_\_\_\_  
\_\_\_\_\_

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

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

- Teachers  Coach/PE  Office Staff  Bus Driver/Transportation