SEIZURE ACTION PLAN

Student Name: _____ Date of birth: _____ Grade: _____

School: _____ Phone #: _____ Fax #: _____

Physician to complete:

SEIZURE INFORMATION:

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Student's response after a seizure: _____

BASIC FIRST AID: CARE & COMFORT

Does student need to leave the classroom after a seizure? ☐ **YES** ☐ **NO**

If YES, describe process for returning student to class _____

_____

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 (grand mal) 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)*

☐ 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)

Medication	Route	Dosage	Frequency

Does student have a **Vagus Nerve Stimulator (VNS)**? ☐ YES* ☐ NO **If YES, Please complete SPHCS Physician's Authorization.*

Special Considerations and Safety Precautions: _____

Physician's Name (print): _____ **Signature:** _____ **Date:** _____

License No.: _____ **NPI #:** _____ **Office Telephone #:** _____ **Office Fax #:** _____

I authorize the school nurse, or other appropriately assigned school staff, to administer the medication/perform the procedure, as prescribed here in by the authorized health care provider. I will notify the school immediately and submit a new form, if there are any changes in the medication, procedure or the prescribing physician. I understand that school health staff are obliged by law to clarify issues associated with this order with the prescribing provider as necessary.

Parent/Guardian Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____