

Student  
Photo

# SEIZURE ACTION PLAN

School \_\_\_\_\_ 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. \_\_\_\_\_

## EMERGENCY CONTACTS:

NAME	RELATIONSHIP	TELEPHONE NUMBER

Treating Physician \_\_\_\_\_ Telephone \_\_\_\_\_

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

Allergies \_\_\_\_\_

Triggers or warning signs \_\_\_\_\_

BASIC SEIZURE FIRST AID	WHEN IS A SEIZURE AN EMERGENCY?	EMERGENCY RESPONSE
<ul style="list-style-type: none"> <li>Stay calm and track time</li> <li>Keep student from injury</li> <li>Do not restrain student</li> <li>Put nothing in student's mouth</li> <li>Turn student on their side</li> <li>Stay with student until conscious</li> <li>Record episode in log</li> </ul>	<ul style="list-style-type: none"> <li>Tonic-clonic convulsions &gt; 5 minutes</li> <li>Repeated seizures without recovery</li> <li>Student is injured</li> <li>Student has Diabetes</li> <li>First episode of seizure for student</li> <li>Seizure occurs underwater</li> <li>Student experiences breathing difficulty</li> <li>Student does not respond to medications</li> </ul>	<ul style="list-style-type: none"> <li>Create a safe physical space</li> <li>Protect student's airway</li> <li>Call school nurse at _____</li> <li>Call 911 for transport to _____</li> <li>Administer emergency medications</li> <li>Notify parent/ emergency contact</li> <li>Other: _____</li> </ul>

## EMERGENCY MEDICATIONS:

	MEDICATION NAME	DOSE	ROUTE	FREQUENCY	SIDE EFFECTS/ SPECIAL INSTRUCTIONS
DAILY					
PRN					

Does this student have permission to self-carry intranasal AED? ☐ Yes ☐ No

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

Protocol following in-school seizure:	Convert to EMERGENCY Protocol if:
<input type="checkbox"/> Rest in clinic under observation <input type="checkbox"/> Return to class after _____ minutes <input type="checkbox"/> Log seizure activity in student's records <input type="checkbox"/> Notify parent/ listed emergency contact <input type="checkbox"/> Other: _____	<input type="checkbox"/> Seizures are back-to-back without return to baseline <input type="checkbox"/> Emergency meds do not stop seizure after _____ minutes <input type="checkbox"/> Student does not return to baseline after _____ minutes <input type="checkbox"/> Seizure does not stop despite activating VNS <input type="checkbox"/> Other: _____

Special Considerations and Safety precautions (regarding school activities, sports, trips): \_\_\_\_\_

Parent/Guardian \_\_\_\_\_  
Printed name Signature Date

Physician \_\_\_\_\_  
Printed name Signature Date