Phone: 704-237-5333 Fax: 704-237-5398

# Seizure Action Plan

This record is to be completed by parents/guardians in consultation with their physician. Please check the appropriate box and print your answers clearly in the blank spaces where indicated. The information on this Plan is confidential. All staff that care for your child will have access to this information. The school will only disclose this information to others with your consent. Please contact the school at any time if you need to update this Plan or you have any questions regarding the management of seizures at school. It is the responsibility of the parent/guardian to assure the Seizure Action Plan is in place for their child and the school is provided with the adequate medication.

**Student Name: _____ DOB: _____**

**Grade: _____ Academic Partner: _____**

**Physician: _____ Phone: _____**

## Emergency Contacts:

| | Name | Relationship | Home# | Work# | Cell # |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |

## Seizure Information:

| Seizure Type | Length | Frequency | Description |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Possible Triggers or Warning Signs _____

_____

Student's Response after a Seizure _____

## Basic Seizure First Aid:

- Stay calm and track time

## Seizure Emergency Protocol: (check all that apply and clarify)

[ ] Contact School Nurse at 704-237-5333

- Keep student safe
- Do not restrain
- Do not put anything in mouth
- Stay with student until fully conscious
- Record seizure in log

[ ] Call 9-1-1 for transport to _____
[ ] Notify parent or emergency contact
[ ] Administer emergency medications as listed 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 first-time seizure
- Student has breathing difficulties
- Student has seizure in water

## If additional care is needed, please describe action here:

_____

_____

## Seizure Medication and Treatment Information:

Medication is needed at school? Yes [ ] No [ ]

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

**Physician Signature** _____ **Date** _____

Parent/Guardian Signature _____ Date _____

Received by School Nurse _____ Date _____