Seizure Action Plan

(Please print) School:

Name	Date of Birth	Effective Date
Healthcare Provider Name:	Parent/Guardian Name:	Emergency Contact Name:
Healthcare Provider Phone Number/Fax Number:	Parent/Guardian Phone Number:	Emergency Contact Phone Number:

Seizure information			
Seizure Type	**Length**	**Frequency**	**Description**

Triggers or warning signs: **Student's response after a seizure:**

Basic First Aid: Care & Comfort	A seizure is considered an emergency when:
• Ensure patient is in a safe position with no sharp objects nearby • Remove any tight clothing or jewelry that may be around patient's neck • Do not forcibly hold the person down • If lying down, turn them to their side to prevent choking • Stay with the person until the seizure is over and record how long it lasts • Do not put anything in patient's mouth	• Convulsive seizure lasts more than 5 minutes • Repeated seizures without regaining consciousness • Student is injured or has diabetes • Student has first time seizure • Student has breathing difficulties • Student has a seizure in water

Seizure Treatment

If the student has a seizure at school:

☐ **Contact the school nurse** ☐ **Notify Doctor**

☐ **Administer Emergency Medications as indicated below** ☐ **Call 911:**_____

☐ **Notify parent/guardian or emergency contact** ☐ **Other:**_____

Treatment Protocol During School Hours (daily and emergency medications)

Emergency Med (√)	Medication	Dosage and Time of Day Given	Common Side Effects and Special Instructions

Does the student have a Vagus Nerve Stimulator? ☐**Yes** ☐ **No** If yes, describe use:

Special Considerations and Precautions (regarding school activities, sports, trips, diet, etc.) Please describe below:

Healthcare Provider Signature:_____ **Date:**_____

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