SEIZURE ACTION PLAN

Student Photo

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 ____ Birthdate ______________________

Mother/Guardian ________________________________ Home Tel ____________________________

Cell _____________________________ Work Tel _____________________________

Father/Guardian _________________________________ Home Tel ____________________________

Cell _____________________________ Work Tel _____________________________

Treating Physician _______________________________________ Tel ___________________________

Significant Medical History ____

Current Medications ____

Allergies ____

SEIZURE EMERGENCY PROTOCOL

- ☐ Diazepam rectal gel ___________ mg rectally PRN for seizure > _______ minutes OR for ___________ or more seizures in ____________ hours. Following administration of Diazepam rectal gel, call parents to pick up child.
- ☐ Use Vagal Nerve Stimulator (VNS) magnet
- ☐ Other ____

Call 911 if

- ☐ Seizure does not stop by itself or with VNS within ____________ minutes
- ☐ Seizure does not stop within ____________ minutes of giving Diazepam rectal gel
- ☐ Child does not start waking up within __________ minutes after seizure is over (NO Diazepam rectal gel given)
- ☐ Child does not start waking up within __________ minutes after seizure is over (AFTER Diazepam rectal gel is given)

Following a seizure

- ☐ Child should rest in clinic.
- ☐ Child may return to class (specify time frame ____)
- ☐ Notify parents immediately.
- ☐ Send a copy of the seizure record home with child for parents.
- ☐ Notify physician.
- ☐ Other____

Please provide instructions if student requires emergency medication while using school transportation and/or special considerations and safety precautions (regarding school activities, sports, trips, etc.)

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Seizure Information - Student may experience some or all of the listed symptoms during a specific seizure.

Seizure Type(s)	*Description*	
☐ Absence	•Staring •Eye blinking	•Loss of awareness •Other ____________________
☐ Simple partial	•Remains conscious •Distorted sense of smell, hearing, sight	•Involuntary rhythmic jerking/twitching on one side •Other ____________________
☐ Complex partial	•Confusion •Not fully responsive/unresponsive	•May appear fearful •Purposeless, repetitive movements •Other ____________________
☐ Generalized tonic-clonic	•Convulsions •Stiffening •Breathing may be shallow •Lips or skin may have blush color	•Unconsciousness •Confusion, weariness, or belligerence when seizure ends •Other ____________________

Seizure usually lasts _____________ minutes and returns to baseline in_________________ minutes.

Triggers or warning signs ____

Call parents under the following circumstances

1. ____

2. ____

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

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

Authorization for the Release of Information: I hereby give permission for ________________school to exchange specific confidential medical information with _________________(physician/clinic) on my child _____________________to develop more effective ways of providing for the healthcare needs of my child in school.

Signatures:

______________________________________ ____________________

Parent/Guardian Signature **Date**

______________________________________ ____________________

Physician Signature **Date**