SEIZURE ACTION PLAN

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's Name:______________________________________ Date of Birth:_________

Parent/Guardian:______________________________________ Phone: _____________ Cell:_______________

Treating Physician:____________________________________ Phone: _____________

Significant medical history:____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs: ____

Student's reaction to seizures: ____

BASIC FIRST AID: CARE & COMFORT: **(Please describe basic first aid procedures)**

____

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

If YES, describe process for returning student to classroom

____

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as:

____

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- ☐ Contact school nurse at ___________________________________
- ☐ Call 911 for transport to ___________________________________
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other____

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

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Emergency medication & Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator (VNS)**? YES N

If YES, Describe magnet use____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: ***(regarding school activities, sports, trips, etc.)***

____

I give permission to the school nurse or delegate(s) to administer medication and to follow the written instructions provided by the Health Care Provider as indicated on my child's Seizure Action Plan. This plan and medication will be used in case of an emergency and accompany the student off school property. This information may be shared with teacher(s), administrators, bus drivers and other appropriate school personnel with a need to know.

Physician Signature:____ **Date:**____________________

Parent Signature:____ **Date:**____________________

Reviewed by: ____ **Date:** ____________________

*Refer to 504 coordinator if appropriate

Updated 7/16

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Seizure Observation Record

Student Name:				
Date & Time				
Seizure Length				
Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)				
Conscious (yes/no/altered)				
Injuries? (briefly describe)				
Muscle Tone/Body Movements	Rigid/clenching			
	Limp			
	Fell down			
	Rocking			
	Wandering around			
	Whole body jerking			
Extremity Movements	(R) arm jerking			
	(L) arm jerking			
	(R) leg jerking			
	(L) leg jerking			
	Random Movement			
Color	Bluish			
	Pale			
	Flushed			
Eyes	Pupils dilated			
	Turned (R or L)			
	Rolled up			
	Staring or blinking (clarify)			
	Closed			
Mouth	Salivating			
	Chewing			
	Lip smacking			
Verbal Sounds (gagging, talking, throat clearing, etc.)				
Breathing (normal, labored, stopped, noisy, etc.)				
Incontinent (urine or feces)				
Post-Seizure Observation	Confused			
	Sleepy/tired			
	Headache			
	Speech slurring			
	Other			
Length to Orientation				
Parents Notified? (time of call)				
EMS Called? (call time & arrival time)				
Observer's Name				

Please put additional notes on back as necessary.

Questionnaire for Parents of Child with Seizures

School ________________________________ Grade________ Teacher__________________________
Parent's Name_________________________ Telephone (H) _____________(W)__________________
Doctor (for seizures) _____________________Telephone_______________________________________

The following information is helpful to your child's school staff in determining any special needs for your child. Please answer the questions to the best of your ability. If you desire a conference with the school nurse, please call for an appointment.

1. At what age did seizure activity begin? ____
2. What kind of behaviors were observed during a seizure? ______________________________________
   ____
3. When was your child's last seizure? ____
4. How often did seizures occur? ____
5. How long did seizures last? ____
6. What events might trigger a seizure? ____
7. Was there any aura (visual, auditory, olfactory) present before seizure?
   ____
8. Does illness affect your child's seizure control? _______________________________________
9. Has your child experienced a seizure lasting longer than five minutes? Yes No
   If yes, what intervention was needed? ____
10. Has your child ever been hospitalized related to seizures? If yes, please explain:
    ____
    ____
11. How does your child react after a seizure is over? ___________________________________
12. Are there any safety precautions/restrictions that school should be aware of?
    ____
13. Please list the medications your child takes for epilepsy (every day and as needed)
    Name of Medication Dose Frequency
    (In School)____
    ____
    (At Home)____
    ____
14. If your child does not respond to medication, what action do you advise the school personnel to take?
    ____
    ____
15. What, if any, side effects does your child have from his/her medication?
    ____
16. Can this information be shared with staff involved in your child's learning? ______________________
17. Please list emergency contacts if you are not available:
    Name Relationship to child Phone Number
    ____
    ____

Parent/Guardian Signature: __________________________________ Date: ______________________

Please provide other pertinent information on the back of this questionnaire. Thank you!