EPILEPSY FOUNDATION®
Not another moment lost to seizures™

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 seizure:_____

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

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

EMERGENCY RESPONSE:

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

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

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_____

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

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

Emergency/Rescue Medication

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use_____

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

Physician Signature:_____ **Date:**_____

Parent Signature:_____ **Date:**_____

Authorization To Give Medication At School (Prolonged Time Period)

If medication can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed. Please write one medication per page.

Student's Name: _____

Teacher: _____ **Grade:** _____

I request that _____School, through the principal or designee supervise/assist in the administering of mediation to my child according to instructions the instructions below. I understand that:

- Medications must be in the original labeled container (no baggies foil, etc.) Pharmacies can provide a duplicate labeled container with only the school doses.
- Parent/guardian must provide special instructions, as well as the medication and related equipment to the principal or clinic personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medications or new doses will not be given unless a new form is competed and a newly labeled container is provided.
- All medications will be taken directly to the office/clinic by the parent/guardian.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

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Name of medication: _____

Dose: _____ Route (by mouth, topical, etc.): _____

Time(s) to be given: _____ Stop medication on: _____

Physician's Name: _____ Physician's Phone: _____

I hereby authorize the school personnel, employees and officials of the _____School District to assist my child in taking prescribed medication according to district policy and I release them form any liability for administering this medications I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

_____ _____

Parent/Legal Guardian *Date*

Home Phone _____ Work Phone _____ Pager/Cell Phone _____

To be completed by healthcare provider for prescription medications given for more than two weeks.

Condition/Illness Requiring Medication: _____

Possible Side Effects if any:_____

_____

Signature of Healthcare Provider ***Date***