SPECIAL SCHOOL DISTRICT SEIZURE ACTION PLAN

(Adapted from the Epilepsy Foundation, 3/24/09) Form #SZ 2

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: ________________________

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

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:**_________