

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 _____ |
| Other Emergency Contact _____ | Phone _____ Cell _____ |
| Treating Physician _____ | Phone _____ |
| Significant Medical History _____ | |

Seizure Information

| Seizure Type | Length | Frequency | Description |
|--------------|--------|-----------|-------------|
| | | | |
| | | | |
| | | | |

Seizure triggers or warning signs: _____ Student's response after a 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 seizure:**
- Protect head
 - Keep airway open/watch breathing
 - Turn child on side

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
- Administer emergency medications as indicated below
- Notify doctor
- Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

| Emerg. Med. ✓ | Medication | Dosage & Time of Day Given | Common Side Effects & Special Instructions |
|---------------|------------|----------------------------|--|
| | | | |
| | | | |
| | | | |

Does student have a Vagus Nerve Stimulator? Yes No If YES, describe magnet use: _____

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions: _____

Physician Signature _____ Date _____
Parent/Guardian Signature _____ Date _____

Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Contact Information

| | | | |
|---|-------------|---------------|------|
| Student's Name | School Year | Date of Birth | |
| School | Grade | Classroom | |
| Parent/Guardian | Phone | Work | Cell |
| Parent/Guardian Email | | | |
| Other Emergency Contact | Phone | Work | Cell |
| Child's Neurologist | Phone | Location | |
| Child's Primary Care Doctor | Phone | Location | |
| Significant Medical History or Conditions | | | |

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? _____

2. Seizure type(s) _____

| Seizure Type | Length | Frequency | Description |
|--------------|--------|-----------|-------------|
| | | | |
| | | | |
| | | | |
| | | | |

3. What might trigger a seizure in your child? _____

4. Are there any warnings and/or behavior changes before the seizure occurs? YES NO

If YES, please explain: _____

5. When was your child's last seizure? _____

6. Has there been any recent change in your child's seizure patterns? YES NO

If YES, please explain: _____

7. How does your child react after a seizure is over? _____

8. How do other illnesses affect your child's seizure control? _____

Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? YES NO

If YES, what process would you recommend for returning your child 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 seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)
12. Has child ever been hospitalized for continuous seizures? YES NO
If YES, please explain:

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Seizure Medication and Treatment Information

13. What medication(s) does your child take?

| Medication | Date Started | Dosage | Frequency and Time of Day Taken | Possible Side Effects |
|------------|--------------|--------|---------------------------------|-----------------------|
| | | | | |
| | | | | |

14. What emergency/rescue medications are prescribed for your child?

| Medication | Dosage | Administration Instructions (timing* & method**) | What to Do After Administration |
|------------|--------|--|---------------------------------|
| | | | |
| | | | |

* After 2nd or 3rd seizure, for cluster of seizure, etc.

** Orally, under tongue, rectally, etc.

15. What medication(s) will your child need to take during school hours? _____
16. Should any of these medications be administered in a special way? YES NO
If YES, please explain: _____
17. Should any particular reaction be watched for? YES NO
If YES, please explain: _____
18. What should be done when your child misses a dose? _____
19. Should the school have backup medication available to give your child for missed dose? YES NO
20. Do you wish to be called before backup medication is given for a missed dose? YES NO
21. Does your child have a Vagus Nerve Stimulator? YES NO
If YES, please describe instructions for appropriate magnet use: _____

Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

- | | |
|---|--|
| <input type="checkbox"/> General health _____ | <input type="checkbox"/> Physical education (gym/sports) _____ |
| <input type="checkbox"/> Physical functioning _____ | <input type="checkbox"/> Recess _____ |
| <input type="checkbox"/> Learning _____ | <input type="checkbox"/> Field trips _____ |
| <input type="checkbox"/> Behavior _____ | <input type="checkbox"/> Bus transportation _____ |
| <input type="checkbox"/> Mood/coping _____ | <input type="checkbox"/> Other _____ |

General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? _____
24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Dates _____

Updated _____

Parent/Guardian Signature _____ Date _____