

SEIZURE ACTION PLAN / ICD Code _____

Student's Name: _____ Date of Birth: _____ Grade: _____ Year _____

Parent/Guardian: _____ Phone: _____ Cell: _____

Treating Physician: _____ Phone: _____ FAX: _____

Significant medical history: _____

SEIZURE INFORMATION:

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

BASIC FIRST AID: CARE & COMFORT: *(Please describe first aid procedures if different than Basic Seizure First Aid)*

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:

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 _____

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)

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

Emergency/Rescue Medication

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

If YES, describe process for returning student to classroom: _____

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

I give permission to follow the above action plan and to share information with school staff and the healthcare provider about my child's medical condition so that they can work together to help my child manage his/her medical condition. This plan, when signed and dated allows my child's medicine to be administered at school as ordered by my child's licensed prescriber and on school field trips and remains current for this school year. I release the school personnel from liability in the event any reaction results from the medication.

Physician Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____