SEIZURE ACTION PLAN

Place Child's Picture Here

Student Name_____ _____

Date of Birth _____ School Year _____

Parent/Guardian_____ ____Phone _____ Cell _____

Other Emergency Contact _____ Phone _____ Cell _____

Treating Physician _____ Phone _____

Seizure Information

Type of seizure disorder _____ Describe: _____
Seizure triggers or warning signs: _____
Student Response after a seizure: _____
Does student need to leave the classroom after a seizure? ❑ Yes ❑ No

Basic First Aid: Care and Comfort	**Emergency Response**
• Stay calm and track time • Keep child safe • Do not restrain • Do not put anything in mouth • Stay with child until fully conscious • Record seizure in log (if applicable) **For convulsive (tonic-clonic) seizure:** • Protect head • Keep airway open/watch breathing • Turn child on side	**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 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
❑ Administer emergency medications as indicated _____ _____
_____ _____
❑ Notify doctor
❑ Other _____ _____

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I authorize the release of information about the specialized health care procedures/services related to my child's condition between the child's prescribing physician, the school nurse, and school personnel who care for my child and may need to know this information to maintain my child's health and safety. This authorization will be in effect for the above stated school year.

Parent/Guardian Signature _____ Date _____

Physician Signature _____ Date _____

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SEIZURE QUESTIONNAIRE

Contact Information

Student Name_____ School Year _____Date of Birth _____

Grade_____ School _____Teacher/Team_____ _____

Parent/Guardian _____Phone _____ Work _____ Cell _____ _____

Parent/Guardian Email _____

Child's Neurologist _____ Phone _____ Location _____

Child's Primary Doctor _____ Phone _____ Location _____

Seizure Information

When was your child diagnosed with seizures or epilepsy? _____

Seizure Type	Length	Frequency	Description

What might trigger a seizure in your child?_____
Are there any warning and/or behavior changes before the seizure occurs? ❑ Yes ❑ No
If YES, please explain: _____
When was your child's last seizure? _____
Has there been any recent change in your child's seizure patterns? ❑ Yes ❑ No
If YES, please explain: _____
How does your child react after a seizure is over? _____
How do other illnesses affect your child's seizure control? _____

Seizure Medication and Treatment Information

What medication(s) does your child take?

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

What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* and method*)	What to do after Administration

After 2nd or 3rd seizure, for cluster of seizure, etc. **Orally, under tongue, rectally, etc.

What medication(s) will your child need to take during school hours? _____
Should any of these medications be administered in a special way? ..Yes ..No
If YES, please explain: _____
What should be done when your child misses a dose? _____

Parent/Guardian Signature_____ Date _____

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