**SEIZURE ACTION PLAN**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Student Name: |       | Date of birth: |       | Grade: |       |  |
| School: |       | Phone #: |       | Fax #: |       |  |
|  |  |  |  |  |  |  |

Physician to complete:

**SEIZURE INFORMATION:**

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

|  |  |
| --- | --- |
| Seizure triggers or warning signs: |       |
| Student’s response after a seizure: |       |

# BASIC FIRST AID: CARE & COMFORT

**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

# *BASIC SEIZURE FIRST AID:*

* *Keep the child safe*
* *Explain to others*
* *Do not restrain*
* *Do not put anything in mouth*
* *Stay with child until fully conscious*

*For tonic-clonic*

* *Turn child on side*

*Cushion head*

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

If YES, describe process for returning student to class \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## EMERGENCY RESPONSE:

A “seizure emergency” for this student is defined as: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Seizure Emergency Protocol: *(Check all that apply and clarify below)*

[ ]  Call 911 for transport to

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

[ ]  Notify parent or emergency contact

[ ]  Notify doctor

[ ]  Administer emergency medications as indicated below

[ ]  Other

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

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Route | Dosage | Frequency |
|       |       |       |       |
|       |       |       |       |

Does student have a **Vagus Nerve Stimulator (VNS)**? [ ]  YES\* [ ]  NO *\*If YES, Please complete SPHCS Physician’s Authorization.*

Special Considerations and Safety Precautions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Physician’s Name (print):** |       | **Signature:** |       | **Date:** |       |  |
| **License No.:** |       | **NPI #:** |       | **Office Telephone #:** |       | **Office Fax #:** |       |  |
|  |

|  |
| --- |
| I authorize the school nurse, or other appropriately assigned school staff, to administer the medication/perform the procedure, as prescribed here in by the authorized health care provider. I will notify the school immediately and submit a new form, if there are any changes in the medication, procedure or the prescribing physician. I understand that school health staff are obliged by law to clarify issues associated with this order with the prescribing provider as necessary. |
| **Parent/Guardian Signature:** |       | **Date:** |       |  |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **School Nurse Signature:** |       | **Date:** |       |  |
|  |  |  |  |  |