Effective Date: _____

# Seizure Action Plan

Office Use Only
☐ Uploaded to Synergy Documents
☐ Synergy (2)
☐ Notify RN, copy sent via pony
Initials/date_____

Student's Name _____ Date of Birth _____
Parent/Guardian _____ Phone _____

## Seizure Information:

| Seizure Type | How Long it Lasts | How Often | What Happens |
|---|---|---|---|
| | | | |
| | | | |

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 of returning student to classroom:
_____
_____

**Basic Seizure First Aid**

- **STAY** calm, begin timing seizure
- Keep **SAFE**-remove harmful objects, don't restrain, protect head
- SIDE- turn on side if not awake, keep airway clear, don't put objects in mouth
- STAY until recovered from seizure
- Record what happens

## Seizure Emergency Protocol:

(Check all that apply and clarify below)
☐ Call 911 for transport to _____
☐ Notify parent or emergency contact
☐ Administer emergency medications
☐ Other

_____
_____

**A seizure is generally considered an emergency when:**

- Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available.
- Repeated seizures longer than 10 minutes, no recover between them, not responding to rescue med if available.
- Student has difficulty breathing at any point.
- Serious Injury occurs or suspected seizure in water.
- Student has a first-time seizure or student is diabetic.

## Emergency Seizure Medication:**

| Medication Name | Dose | When to give | How to give | Frequency |
|---|---|---|---|---|
| | | | | |

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: _____

Treating Physician _____ Physician Signature_____ Phone _____

I have reviewed this plan with my child's physician. I give Carman-Ainsworth school staff permission to treat my child according to this plan. I understand this information will be shared with school staff members who may need to know this information to maintain my child's health and safety. I will update the school with any changes to my child's plan. I give permission for exchange of verbal and written communication between the physician and the school nurse and/or designated school staff regarding this plan.

Parent/Guardian Signature_____ Date_____/_____/_____

Parent/Guardian Name_____ Phone_____

****Must also fill out Medication Authorization Form(s) for each medication the child may need to take at school.**

Adapted from the Epilepsy Foundation

Updated/Reviewed 2/22 SK