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 the student need to leave the classroom after a seizure? ☐ Yes ☐ No

If YES, describe the process for returning the student to the 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 seizures:

- 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 the student have a **Vargus Nerve Stimulator?** ☐ Yes ☐ No If YES, describe magnet use:

Please provide a completed Medication Authorization Form per Valley View School District Policy, for medication administration at school.

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

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____