EPILEPSY FOUNDATION®
Not another moment lost to seizures

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

If YES, describe process for returning student to 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 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

❒ 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 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:

Physician Signature ____________________________ **Date** ______________

Parent/Guardian Signature ____________________________ **Date** ______________

DPC772

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Seizure Record

Name ____

Agency ____

Physician (Neurologist) ______________________________

	DAY																																							
YEAR	MONTH																																							
Description	Conscious																																							
	Unconscious																																							
	Confused																																							
	Fell																																							
	Became limp																																							
	Became stiff																																							
	Flush																																							
	Pale																																							
	Cyanotic/blue																																							
Body Movements	Jerking																																							
	Twitching face																																							
	Chewing motion																																							
	Tongue biting																																							
	Excessive drooling																																							
	Eyes rolled back																																							
	Eyes staring																																							
	Eyes blinking																																							
	Wet bed/self																																							
	Bowel movement/seizure																																							
Behavior After Seizure	Sleepy/tired																																							
	Alert																																							
	Confused																																							
	Headache																																							
	Temporary paralysis																																							
	Unsteady walking																																							
	Slurred speech																																							
	Increased activity																																							
	Unusual activity																																							
	Time of Day																																							
	Duration (# min.)																																							
	Staff Initials																																							

Medication Form/Physician's Order (To be Completed by the Physician/Authorized Health Care Provider)

School: _______________ Grade: ____ Date of Order: _________ Order Expires End of School Year or (date): _________

Student Name: __________________________________ Order valid for current year/Summer (check if appropriate) ☐

DOB: _______ Gender: M F Allergies: ____

Name of Medication: _________________ Dose: ________ Route: __________ Time to Give Medication: __________

Reason for Medication: ______________________________ Frequency of Medication (IF PRN):_________________

Possible Side Effects: ____

Student may carry and self-administer emergency medication: ☐Yes ☐No

Parent/Guardian Name:	**Physician Name:**	**Phone:**
Phone:	**Address:**	
PARENT SIGNATURE:	**PRESCRIBER SIGNATURE:**	

Medication Administration Record (For School/Camp Use Only)

Nurse Reviewed: **Dates Reviewed:**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
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June																															
July																															

Name/Position	Initials	Name/Position	Initials
___________________________	______	___________________________	______
___________________________	______	___________________________	______
___________________________	______	___________________________	______
___________________________	______	___________________________	______

CODES: Chart Reason (see H.S. Manual)

X: School Closed FT: Field Trip
A: Absent: R: Refused
N: None Available O: Omitted
NS: No Show to HR H: Dose Held
D/C: Med. Discontinued
L/E: Late Arrival/Early Dismissal

RN Signature: ______________________________ **Date:** _________

Medication Administered (This side for school use only)

Student Name:

Date	Time	Student Complaint	R.N. Consulted ✓	Medication Administered as Ordered ✓	Student Outcome	Staff Initials	Parent Notified ✓
Comments:							