SEIZURE ACTION PLAN

Student Photo Here

Student Name _____ Birthdate _____ Grade _____

Effective Date: School Year 20 ___- ___ (including summer school) **OR** From _____To _____

To be completed by a practitioner:

EMERGENCY SEIZURE MEDICATIONS

Give medication at □ onset of seizure □ for seizure lasting longer than __ minutes or □ _____

_____

_____

Medication Dosage Route

_____

_____

Medication Dosage Route

BASIC SEIZURE FIRST AID

- Stay calm
- Track time of onset and length of seizure
- Do not restrain child
- Do not put anything in mouth
- Remain with child until fully conscious
- Protect head
- Keep airway open and monitor breathing
- Turn child on side after seizure ends

EMERGENCY RESPONSE

- Follow Basic Seizure First Aid
- Administer emergency medications as indicated above
- Notify parent or emergency contact and school nurse
- Other _____

_____

_____

_____

ALWAYS CALL 911 IF:

- Emergency seizure medication was given
- A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has breathing difficulties
- Student has a seizure in water

SEIZURE INFORMATION

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

DAILY SEIZURE MEDICATIONS TAKEN AT SCHOOL

_____

Medication Dosage Frequency Route

_____

_____

Medication Dosage Frequency Route

SPECIAL CONSIDERATIONS AND SAFETY PRECAUTIONS (school sponsored activities/events, sports, trips)

_____

_____

PARENT/GUARDIAN SIGNATURE _____ Phone _____ Date _____

I hereby give permission to staff designated by the school principal or nurse to give the above medication to my student according to the instructions stated above and authorize them to contact the practitioner, if necessary.

PRACTITIONER SIGNATURE _____ Phone _____ Date _____

Practitioner signature directs the above medication administration and indicates willingness to communicate with school staff regarding this medication.

SEIZURE OBSERVATION RECORD

Student Name: Date of birth: Grade:

Parent Name:	Phone: Home	Cell:	Work:	
Seizure Date & Time				
Seizure Length (minutes/seconds)				
Pre-Seizure Observation(Briefly list behaviors, triggering events, activities)				
Conscious (yes/no/altered)				
Injuries (briefly describe)				
Muscle Tone/ Body Movements	Rigid/clenching			
	Limp			
	Fell down			
	Rocking			
	Wandering around			
	Whole body jerking			
Extremity Movements	arm jerking-R or L			
	(R) leg jerking- R or L			
	Random Movement			
Color	Bluish			
	Pale			
	Flushed			
Eyes	Pupils dilated			
	Turned (R or L)			
	Rolled up			
	Staring or blinking (clarify)			
	Closed			
Mouth	Salivating			
	Chewing			
	Lip smacking			
Sounds (gagging, talking, throat clearing)				
Breathing (normal, labored, stopped, noisy)				
Incontinent (urine or feces)				
Post-Seizure Observation	Confused			
	Sleepy/tired			
	Headache			
	Speech slurring			
	Other			
Time to fully awake/aware				
Parents Notified? (time of call)				
EMS Called? (call time & arrival time)				
Observer's Name				