Seizure Action Plan

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Effective Date ____________________

Student's Name:__________________________ Date of Birth:___________ Classroom:_____

Parent/Guardian/Relative Caregiver:__________ Phone:_________________ Cell:__________

Treating Physician:________________________ Phone:_________________

Medical History:____

____

Seizure Information:

1. When was your child diagnosed with seizures or epilepsy?________________________________
2. Seizure type(s):

Seizure Type	*Average length*	*Description*

3. What might trigger a seizure in your child?____
4. Are there any warnings, triggers and/or behavior changes before the seizure occurs? YES NO
   If YES, please explain:____
5. How often does your child have a seizure?____
6. When was your child's last seizure?____
7. Has there been any recent change in your child's seizure patterns? YES NO
   If YES, please explain:____
8. How does your child react after a seizure is over?_____________________________________
   How long does this usually last?____
9. How do other illnesses affect your child's seizure control?_______________________________

Seizure Medication and Treatment Information:

10. What medication(s) does your child take?

Medication	*Date Started*	*Dosage*	*Frequency and time of day taken*	*Possible side effects*
1.				
2.				
3.				

Student's Name__________________________________

Emergency Response:

A "seizure emergency" for this student is defined as:_______________________________________
____

11. What emergency/rescue medications are prescribed for your child?

Name	*Dosage*	*Administration instructions (timing* & method**)*	*What to do after administration:*
1.			
2.			

** After 2nd or 3rd seizure, for cluster of seizure, etc.* *** Orally, under tongue, rectally, etc.*

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

☐ Contact school nurse at _________________________
☐ Call 911 for transport to ________________________
☐ Notify parent or emergency contact ______________
Telephone number ______________________________
☐ Notify doctor ________________________________
Telephone number ______________________________
☐ Administer emergency medications as indicated
☐ Other _______________________________________

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, has diabetes, or is pregnant
- Student has breathing difficulties

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO
If YES, describe magnet use____

Special Considerations & Safety Precautions:

(regarding school activities, sports, trips, etc.)

Physician Signature:____ Date:_______________

Parent Signature:____ Date:_______________

This form combines two forms (one for parents and one for physician) created by the Epilepsy Foundation and the National Association of School Nurses. Reviewed by Barbara Blair (Delaware) in 2011.