HEALTH SERVICES

SEIZURE ACTION PLAN

STUDENT NAME:________________________________**Date of Birth**:____________

MEDICAL DIAGNOSIS/HISTORY:____

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____

SEIZURE INFORMATION:

Seizure type(s):

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Length of Seizure: ____

Frequency of Seizure: ____

Seizure triggers or warning signs:____

Student's reaction to seizure:____

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, describe criteria and procedure for magnet use: __________________________________

____

____

BASIC FIRST AID: CARE & COMFORT-Before Arrival of School Nurse or Trained Personnel

- Alert School Nurse at ____
- Note time seizure begins
- Keep student safe from harm-protect head
- Do NOT restrain
- Do NOT place anything in mouth
- Do NOT leave student unattended
- Document student's behaviors that occurred before, during and after seizure
- Keep student on left side
- Other: ____

TREATMENT/ RESPONSE-School Nurse or Trained Personnel:

- **Alert 911/EMS for the following: (Check ALL that apply):**

_____ Tonic-Clonic Seizure > 5 minutes _____ Repeated seizures without regaining consciousness

_____ Student has Diabetes _____ Student has seizure in water _____ Student is injured

- **Administer the following medications as directed:**

Medication: ______________________________ Dose: ______________

Route: ____________________ Frequency: ______________________

Medication: ______________________________ Dose: ______________

Route: ____________________ Frequency: ______________________

Medication: ______________________________ Dose: ______________

Route: ____________________ Frequency: ______________________

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

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SPECIAL NOTATIONS/CONSIDERATIONS FROM PHYSICIAN: ____________________

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Parent Signature:______________________________**Date:**______________

Physician Name, Address and Office Phone: ______________________________

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Physician Signature:______________________________**Date:**______________