



# 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 \_\_\_\_\_

Please return to:



Student name: \_\_\_\_\_

# QUESTIONNAIRE FOR PARENT OF A STUDENT WITH SEIZURES

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.

## CONTACT INFORMATION:

Student's Name: \_\_\_\_\_ School Year: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Classroom: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Tel. (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

Other Emergency Contact: \_\_\_\_\_ Tel. (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

Child's Neurologist: \_\_\_\_\_ Tel: \_\_\_\_\_ Location: \_\_\_\_\_

Child's Primary Care Dr.: \_\_\_\_\_ Tel: \_\_\_\_\_ Location: \_\_\_\_\_

Significant medical history or conditions: \_\_\_\_\_

## SEIZURE INFORMATION:

1. When was your child diagnosed with seizures or epilepsy? \_\_\_\_\_

2. Seizure type(s):

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>

3. What might trigger a seizure in your child? \_\_\_\_\_

4. Are there any warnings and/or behavior changes before the seizure occurs? YES NO

If YES, please explain: \_\_\_\_\_

5. When was your child's last seizure? \_\_\_\_\_

6. Has there been any recent change in your child's seizure patterns? YES NO

If YES, please explain: \_\_\_\_\_

7. How does your child react after a seizure is over? \_\_\_\_\_

8. How do other illnesses affect your child's seizure control? \_\_\_\_\_

## BASIC FIRST AID: Care and Comfort Measures

9. What basic first aid procedures should be taken when your child has a seizure in school? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 (grand mal) seizure:

- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

10. Will your child need to leave the classroom after a seizure? YES NO

If YES, What process would you recommend for returning your child to classroom: \_\_\_\_\_

**SEIZURE EMERGENCIES**

Student name: \_\_\_\_\_

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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 or diabetic
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

12. Has child ever been hospitalized for continuous seizures? YES NO  
 If YES, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**SEIZURE MEDICATION AND TREATMENT INFORMATION**

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

Medication	Date Started	Dosage	Frequency and time of day taken	Possible side effects

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

Medication	Dosage	Administration Instructions (timing* & method**)	What to do after administration:

\* After 2<sup>nd</sup> or 3<sup>rd</sup> seizure, for cluster of seizure, etc.

\*\* Orally, under tongue, rectally, etc.

15. What medication(s) will your child need to take during school hours? \_\_\_\_\_

16. Should any of these medications be administered in a special way? YES NO  
 If YES, please explain: \_\_\_\_\_

17. Should any particular reaction be watched for? YES NO  
 If YES, please explain: \_\_\_\_\_

18. What should be done when your child misses a dose? \_\_\_\_\_

19. Should the school have backup medication available to give your child for missed dose? YES NO

20. Do you wish to be called before backup medication is given for a missed dose?

21. Does your child have a Vagus Nerve Stimulator? YES NO

If YES, please describe instructions for appropriate magnet use: \_\_\_\_\_  
 \_\_\_\_\_

**SPECIAL CONSIDERATIONS & PRECAUTIONS**

22. Check all that apply and describe any considerations or precautions that should be taken

- General health: \_\_\_\_\_
- Physical functioning: \_\_\_\_\_
- Learning: \_\_\_\_\_
- Behavior: \_\_\_\_\_
- Mood/coping: \_\_\_\_\_
- Other: \_\_\_\_\_

**GENERAL COMMUNICATION ISSUES**

23. What is the best way for us to communicate with you about your child's seizure(s)? \_\_\_\_\_  
 \_\_\_\_\_

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Dates Updated: \_\_\_\_\_, \_\_\_\_\_

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Please return to: