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** _____

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SEIZURE ACTIVITY LOG

NOTE: This should be accompanied by a *Seizure Care Plan* established and on-file for this child.

Name of Child: _____ Room: _____

DATE	TIME	CIRCUMSTANCES PRECEEDING (activity participating in)	DESCRIBE SEIZURE*	LENGTH OF SEIZURE	ACTIONS TAKEN BY STAFF	CHILD'S BEHAVIOR AFTER SEIZURE	STAFF INITIALS

***What To Look For and Note Above:**

How did the seizure start? Did the seizure start in just one part of the body and then spread, or did it involve the whole body from the beginning?
Was there smacking or licking of the lips? Eyelid fluttering? Picking or fumbling movements of the hands?
Was the child able to respond to any outside stimulus (for example, name called, gently shaking shoulder)? *Was the response normal/confused/no response?*
Were there stiff and/or jerking movements?
Was the jaw clenched or the tongue bitten?
Was there any color change or breathing problem?
How long did the actual seizure last?