Individualized Seizure Action Plan for the 20_____-20_____School Year

This student is being treated for a seizure disorder. The information provided below is intended to assist school personnel should a seizure occur during school hours.

The Following is to be Completed by the Parent

Student's Name_____ DOB_____ Age_____

Allergies_____ Significant Medical History_____

Date of last seizure_____ How long does a typical seizure last?_____

How often do seizures occur?_____

School_____ Grade_____ HR Teacher_____

Parent/Guardian_____ Phone_____ _____

Parent/Guardian_____ Phone_____ _____

The Following is to be Completed by the Medical Provider

Date of seizure diagnosis _____

Medical Diagnosis_____

Current medication(s)_____

_____

Special considerations or safety precautions_____

Student Specific Seizure Emergency Plan Per Medical Provider

Call 911 and parent/guardian for seizure activity in this student for the following:

□ Absence (petit mal) seizure lasting longer than_____ minutes

□ Generalized Tonic Clonic (grand mal) seizure lasting longer than_____ minutes

□ Cluster seizure activity _____ or more seizures in_____ hour

□ Other seizure (indicate type)_____ lasting longer than _____ minutes

□ Administer Diastat (write order here)_____

Basic Seizure First Aid

- Stay calm & note time seizure began
- Keep student safe
- Do not put anything in student's mouth
- Do not restrain
- Protect head
- Stay with student & watch breathing

Other considerations for student with seizure emergency at school:

√ Complete Seizure Observation Form
(Send with EMS if possible)

√ Notify School Nurse (RN)

Treating Physician_____ Phone_____ Fax_____

Physician Signature_____ Date_____

Parent Signature_____ Date_____

School Nurse Signature_____ Date_____ □ IHP