

Seizure Action Plan

Student's Name: _____ DOB: _____ Grade: _____

Parent/Guardian Name: _____ Phone Number: _____

Emergency Contact #1: _____ Phone Number: _____

Primary Physician: _____ Phone Number: _____

Neurologist: _____ Phone Number: _____

Seizure Type	Usual Length	Frequency	Description

Other Information

Triggers: _____

Medical History: _____

Allergies: _____

Device: _____ Vagus Nerve Stimulator _____ Responsive Neurostimulation _____ Deep Brain Stimulation

Date Implanted: _____

Emergency Medication: _____

Special Instructions: _____

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Don't 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

A seizure is generally 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

<p><u>Green Zone</u> < 2 minutes</p>
<ul style="list-style-type: none"> • Begin FIRST AID • Swipe VNS (if ordered) • Allow student to recover from seizure • Notify parent/guardian; return to class or to home as instructed by parent/guardian
<p><u>Yellow Zone</u> 2 to 5 minutes</p>
<ul style="list-style-type: none"> • Continue FIRST AID • Call for help • Re-Swipe VNS if ordered • Prepare to administer Diastat if ordered • Allow student to recover from seizure • Notify parent/guardian; return to class or to home as instructed by parent/guardian
<p><u>Red Zone</u> More than 5 minutes or if 2 or more consecutive seizures total 10 minutes or more</p>
<ul style="list-style-type: none"> • Call 911 • Administer Diastat if ordered • Retrieve AED • Monitor respirations and heart beat and start CPR/AED if needed • Notify parent/guardian • Continue FIRST AID

Medications take at home:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.) Please Describe:

Parental Permission:

I hereby request the school personnel, or its agents, to assist in the seizure management procedure for my child as prescribed by the doctor. I understand that there is no liability on the part of the school district, its agents or its personnel for civil damages as a result of assisting with this procedure when the person acts as an ordinarily reasonable and prudent person would have acted under the same or similar circumstances. I want this plan implemented for my child while at school. I give my permission for exchange of confidential information contained in the record of my child between the nurse and physician and my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

Parent/Guardian Printed Name _____

Signature _____

Date _____