________________________________’s Seizure Action Plan DOB: _______ Classroom/Homeroom__________

Student’s Name

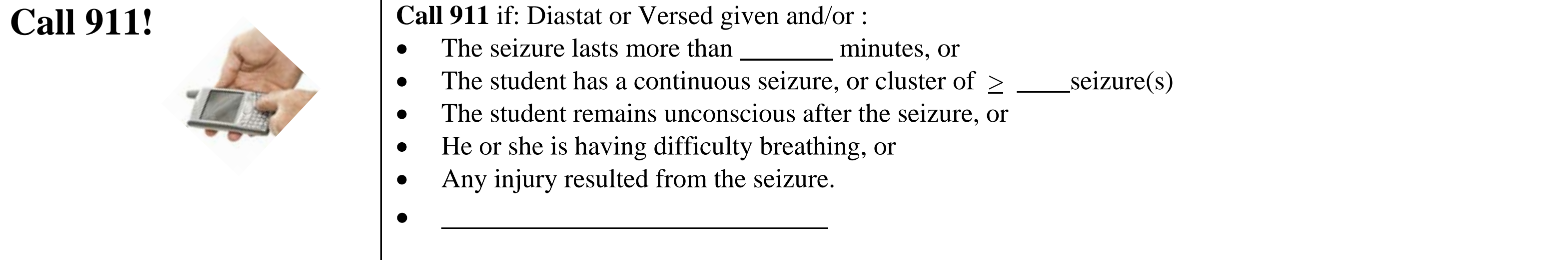
1 Parent/Guardian: ______________________ Phone (w): ________________ (c): _____________ (h): ______________

2 Parent/Guardian: ______________________ Phone (w): ________________ (c): _____________ (h): _____________

Physician: ____________________________ Phone:_________________ Fax: __________________

SEIZURE INFORMATION			
Seizure Type	Length	Frequency	Description

Seizure Triggers or warning signs:	Response after seizure:
Special Considerations and Precautions:	**Dietary Adjustments due to medication:** **(Complete Diet Order if needed)**
Daily Medications:	

TREATMENT	
☐ **Absence** ☐ **Atonic** ☐ **Complex Partial** ☐ **Infantile Spasms**	1. Stay with the student during and after the seizure. Although the student may appear conscious, he/she may lose awareness of surroundings. 2. Be prepared to assist student to the floor if he loses consciousness. 3. Time seizures and watch for clusters. 4. Document seizure in log. 5. Notify parent **Special Instructions:**
☐ **General Tonic/Clonic**	1. Do not restrain movement. Let the seizure run its course. 2. Turn student on side. Loosen the student’s collar. 3. Do not place anything in the mouth. Remove hard, sharp objects from the area. 4. If possible, turn head to the side in the event he/she vomits. (Use “Universal Precautions” if student vomits.) 5. Observe, note time, and be prepared to describe the pattern of the seizure. 6. Record details as they occur or as soon as possible thereafter. 7. Notify parent 8. When seizure is over, allow the student to rest. 9. Stay with the student until fully recovered or parent arrives.
Administer Emergency Medication:	**Diastat Order:** ________Per rectum for seizure lasting ____min or ___or more seizures in a row. **Versed Order:** (May only receive at school if student has history of having used this medication without major side effects.) ____ **Vagus Nerve Stimulator?** ☐ Yes ☐ No If **Yes**, Location of VNS: ________________ Swipe after __________min. Repeat Swipe if: _____________________________________(Please include max number of times to swipe)
Call 911! 	**Call 911** if: Diastat or Versed given and/or : • The seizure lasts more than _______ minutes, or • The student has a continuous seizure, or cluster of $\geq$ ____seizure(s) • The student remains unconscious after the seizure, or • He or she is having difficulty breathing, or • Any injury resulted from the seizure. • ____________________________
Activity Instructions	**OK to swim?** ☐ **no** ☐ yes ☐ needs to wear life vest ☐ needs one on one supervision **Other:** ___________________________________

Physician’s signature required: ________________________________ Date: _____________

I give permission to school staff to give the medication listed above as instructed, and contact MD for questions. My preferred method of notification is: :_____(Notebook) _____(phone) _____(email) _____(text code)

Parent / Guardian Signature: _______________________________ Date: ______________

Attach additional instructions as applicable.