



Calhoun County Public Health Department School Wellness Program



SEIZURE ACTION PLAN

School Fax Number _____

Effective Dates _____

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS. THIS INFORMATION IS CONFIDENTIAL.

Student's Name: _____ Date of Birth: _____
 Parent/Guardian: _____ Phone: _____ Cell: _____
 Treating Physician: _____ Phone: _____
 Significant medical history: _____

SEIZURE INFORMATION:

| Seizure Type | Length | Frequency | Description |
|--------------|--------|-----------|-------------|
| | | | |
| | | | |
| | | | |

Seizure triggers or warning signs: _____
 Student's reaction to 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 _____

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 _____
- Notify doctor _____
- Administer emergency medications as indicated below _____
- Other _____

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

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 has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

| Daily Medication | Dosage & Time of Day Given | Common Side Effects & Special Instructions |
|------------------|----------------------------|--|
| | | |
| | | |

Emergency/Rescue Medication _____

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use _____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

1. As parent/guardian of _____, I give permission for this plan to be available for use in my child's school, and for the nurse consultant to contact the above named physician by phone, fax, or in writing when necessary to complete this plan.
2. It is understood by parents and physicians that this plan may be carried out by school personnel other than the school nurse. The school's Registered Nurse is responsible for delegation of this plan to unlicensed school personnel when appropriate.
3. This plan will be reviewed annually and/or whenever the health status or medications change and it is the responsibility of the parent to notify the school nurse of these changes.

| | |
|-------------------------------|-------------|
| Physician Signature: _____ | Date: _____ |
| Parent Signature: _____ | Date: _____ |
| School Nurse Signature: _____ | Date: _____ |
| Student Signature: _____ | Date: _____ |