SEIZURE ACTION PLAN

NAME _____ DATE OF BIRTH _____ SCHOOL _____

CONTACT INFORMATION

Parent/Guardian Name: _____ Phone: _____

Guardian/Emergency Contact: _____ Phone: _____

Seizure Type: _____ **Triggers:** _____

How long it lasts: _____ **How often/most recent:** _____

Restrictions/Special Accommodations: _____

Does this student need to have rescue medication available on the bus? ☐ yes ☐ no ☐ n/a

Can this student self-carry medication? ☐ yes ☐ no ☐ n/a

SYMPTOMS/WHAT YOU MIGHT SEE	ACTION/WHAT TO DO
_____ _____ _____ _____	**BASIC SEIZURE FIRST AID:** • Stay calm, track time • POSITION ON SIDE- turn on side if having convulsions or not responding • Keep head in neutral position with nothing obstructing nose or mouth • Watch breathing and do not restrain • Do not place anything in the mouth • Record on seizure record • Notify parent/guardian
Seizure EMERGENCY for *this student* (check if applies): ☐ Single seizure has lasted _____ minutes or longer	☐ **No rescue medication ordered** ☐ **Administer rescue medication:** Name of med: _____ Dosage: _____ This applies to: ☐ Only tonic-clonic/convulsive ☐ Any seizure type ☐ **Call 9-1-1** ☐ **Call 9-1-1** if seizure hasn't stopped _____ minutes after receiving rescue medication • Continue Seizure First Aid until help arrives
☐ Clusters of _____ or more seizure in _____ minutes	☐ **No rescue medication ordered** ☐ **Administer rescue medication:** Name of med: _____ Dosage: _____ ☐ **Call 9-1-1** ☐ **Call 9-1-1** if seizures haven't stopped _____ minutes after receiving rescue medication • Continue Seizure First Aid until help arrives
• Student has sustained a potentially serious injury • You are concerned for breathing trouble or color change	• **Call 9-1-1** • Continue Seizure First Aid until help arrives

Additional orders for seizures/medication: _____

Print Physician Name: _____ Date: _____

Physician Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____