

# Seizure Action Plan

Student Name \_\_\_\_\_ ID # \_\_\_\_\_ DOB \_\_\_\_\_ Grade/School year \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Provider Name/Clinic \_\_\_\_\_ Phone \_\_\_\_\_

Activities student participates in at school: \_\_\_\_\_

### Seizure Information

Seizure Type	Length	Frequency	Description

### Signs of Seizures (Please check behaviors that apply to student)

<u>SEIZURE SYMPTOMS</u>	<u>DANGER SIGNS—CALL 911</u>	<u>BEHAVIORS AFTER SEIZURE</u>
<input type="checkbox"/> lip smacking <input type="checkbox"/> behavioral outbursts <input type="checkbox"/> staring <input type="checkbox"/> twitching <input type="checkbox"/> sudden cry or squeal <input type="checkbox"/> falling down <input type="checkbox"/> rigidity/stiffness <input type="checkbox"/> thrashing/jerking <input type="checkbox"/> loss of bowel/bladder <input type="checkbox"/> shallow breathing <input type="checkbox"/> blue color to lips <input type="checkbox"/> froth from mouth <input type="checkbox"/> gurgling/grunting <input type="checkbox"/> loss of consciousness <input type="checkbox"/> other _____	-- Seizure lasts more than 5 minutes -- Student has repeated seizures without regaining consciousness -- Student has breathing difficulties -- Student has a seizure in water -- If seizure is the result of an injury or child is injured during seizure	<input type="checkbox"/> tiredness <input type="checkbox"/> weakness <input type="checkbox"/> sleeping, difficult to arouse <input type="checkbox"/> somewhat confused <input type="checkbox"/> regular breathing <input type="checkbox"/> other _____  Behaviors usually last _____ _____

### Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. <input checked="" type="checkbox"/>	Medication	Dosage & Time of Day Given	Common Side Effects & special Instructions

Does student have a **Vagus Nerve Stimulator**?  Yes  No    If Yes, describe magnet use \_\_\_\_\_

IF YOU SEE THIS	DO THIS
SEIZURE ACTIVITY	Stay calm. Move surrounding objects and protect head to avoid injury. DO NOT hold student down or put anything in the mouth. Loosen clothing if needed. Roll student on his/her side. Document seizure activity on seizure observation record. If applicable administer medications or use VNS as ordered. Notify parent/guardian.
STOPS BREATHING	Begin CPR/Rescue Breathing. Call 911.
LOSS OF BOWEL OR BLADDER CONTROL	Cover with blanket or jacket. If necessary, discreetly assist with changing of clothes after seizure.
DANGER SIGNS-(SEE ABOVE)	Call 911. Call parent/guardian.
FALLS DOWN, LOSS OF CONSCIOUSNESS	Help student to the floor for safety; observe for injury/seizure. Call School Nurse
VOMITING	Turn on side.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

Place Student Picture Here

Seizure observation record on back