Seguin INDEPENDENT SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
exceptional students to exceptional citizens

SEIZURE Action Plan

SY:

Effective Date:

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student:_____ DOB:_____ ID:_____ GR: _____

Parent:_____ Phone:_____ Cell:_____

Emergency Contact: _____ Phone:_____ Cell:_____

Physician: _____ Phone:_____ Fax:_____

Significant Medical History:_____

_____ Date of last seizure: _____

SEIZURE INFORMATION

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Student's response after a 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
- ❒ Administer emergency meds as listed below
- ❒ Notify doctor
- ❒ 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 seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A seizure is generally considered 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 breathing difficulties
- Student has a seizure in water

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

Emerg Med √	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator (VNS)** ❒ Yes ❒ No If **YES**, describe magnet use:

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

Describe any special consideration or precautions:

Physician Signature:_____ Date:_____

Parent/Guardian Signature: _____ Date:_____