

# NDSEC

# SEIZURE ACTION PLAN

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

### **SEIZURE INFORMATION:**

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>

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

**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

### **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 \_\_\_\_\_

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 \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse: \_\_\_\_\_ Date: \_\_\_\_\_