*This page is required **ONLY** if your child has a current diagnosis of Seizures/Epilepsy OR your provider may provide his/her own Action Plan*

2020-2021

SEIZURE ACTION PLAN: Residential & Non-Residential Students

- This section MUST be completed by the Seizure Care Provider (not the parent/guardian)

Student's Name: _____

Seizure Information: Type: _____ Triggers/Warning Signs: _____

Daily, As-Needed & Emergency Seizure Medication (name/dosage/frequency)**:**

1.
2.
3.
4.

Does the student have a **Vagus Nerve Stimulator?** ☐ Yes ☐ No

If YES, describe magnet used:

Action Plan:

1. Stay Calm & track time of seizure (start & end time).
2. Keep child safe.
3. Do not restrain.
4. Do not put anything in mouth.
5. Stay with child until fully conscious.
6. Student may return to the classroom following a seizure as long as fully alert/oriented without any lingering effects from the seizure.
7. Call 911 for a seizure emergency
    - Convulsive (tonic-clonic) seizure that lasts longer than 5-10 minutes.
    - Student has repeated seizures without regaining consciousness.
    - Student is injured or has diabetes.
    - Student has a first-time seizure.
    - Student has breathing difficulties.
    - Student has a seizure in water.
8. Administer emergency medication as indicated above.
9. Notify parent/guardian.

Self-Administration: (please check one)

_____ Student can carry & use the medication listed above at school without supervision.

_____ Student needs supervision or assistance with the above medication at school.

Physician/Provider:

Address: _____Date: _____

Phone #: _____ Fax #: _____ Email: _____

Provider Signature: _____ Provider Printed Name _____

I, the parent/guardian, give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact the seizure care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with the prescribed medication and delivery/monitoring devices:

Parent Signature: _____ Parent Printed Name _____

CC: Tina Brinkman, RN/Nikki Al Khatib, RN