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**SEIZURE ACTION PLAN: Residential & Non-Residential Students**

(IF APPLICABLE)

* This page is required **ONLY** if your child has a current diagnosis of Seizures/Epilepsy OR provide your own action plan
* This section MUST be completed by the Seizure Care Provider (not the parent/guardian)

**Student’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Seizure Care Provider Information:**

Seizure Care Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.

1. Administer emergency medication as indicated above.
2. Notify parent/guardian.

**Comments/Special Instructions:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SEIZURE CARE PROVIDER SIGNATURE PROVIDER PRINTED NAME DATE**

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/GUARDIAN SIGNATURE PARENT/GUARDIAN PRINTED NAME DATE**

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