SEIZURE ACTION PLAN

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student Name_____ Grade _____ Date of Birth _____

Parent/Guardian _____ Best contact phone # _____

Mother's Cell _____ Father's Cell _____

Treating Physician _____ Physician's phone # _____

SEIZURE INFORMATION

When was your child diagnosed? _____

Seizure type(s):

Seizure type (list all)	Average length	*Description*

- _____
- _____
- _____

Seizure triggers or warning signs _____

_____

How often does your child have a seizure? _____ Date of last seizure _____

BASIC FIRST AID: CARE AND COMFORT MEASURES

Describe specific first aid procedures for a seizure at school:_____

_____

_____

Does your child need to leave the classroom after a seizure ? YES NO

SEIZURE MEDICATION

Medication	Date Started	Dosage	Administration Instructions	Follow-up care

1. _____
2. _____
3. _____

TREATMENT PROTOCOL DURING SCHOOL HOURS; (Include Daily & Rescue Medications, dosage, time taken, side effects).

_____

_____

_____

DOES YOUR CHILD HAVE A VAGUS NERVE STIMULATOR? YES NO

SEIZURE EMERGENCIES AND SPECIAL PRECAUTIONS

Please describe what constitutes an emergency for child?
(consult with treatment physician if needed)

_____
_____
_____
_____

Check all that apply and describe any considerations or precautions that should be taken:

_____ General health _____

_____ Physical functioning _____

_____ Learning _____

_____ Behavior _____

_____ Mood/coping _____

_____ Physical education (gym)/sports _____

_____ Recess _____

_____ Field trips _____

_____ Bus transportation _____

GENERAL COMMUNICATIONS & ISSUES

What is the best way for us to communicate with you about your child's seizures?

CAN THIS INFORMATION BE SHARED WITH THE CLASSROOM TEACHER AND OTHER APPROPRIATE SCHOOL PERSONNEL? YES NO

Physician Signature _____ Date _____

Parent Signature _____ Date _____