# SEIZURE ACTION PLAN FOR SCHOOL

Student Name_____D.O.B._____ ID # _____

School _____Teacher_____

Physician _____Phone: _____

Student Picture

**EMERGENCY CONTACTS**

| Name | Relationship | Home # | Work # | Cell # |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

Type of seizure: _____

What does the seizure look like and how long does it usually last?_____

_____

Possible triggers that should be avoided: _____

_____

Does student need any special activity adaptations/protective equipment (e.g., helmet) at school?

_____No _____Yes (explain)_____

_____

Is student allowed to participate in physical education and other activities? _____No _____Yes (explain)

_____

**ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES?** _____No _____Yes (List below the medications needed)

| MEDICATIONS | AMOUNT TAKEN | HOW OFTEN AND FOR WHAT SIGNS |
|---|---|---|
| 1._____ | _____ | _____ |
| 2._____ | _____ | _____ |
| 3._____ | _____ | _____ |

**List medication needed at school (name, dosage/route, and frequency)** _____

_____

**Possible side effects that must be reported to parent or physician:** _____

_____

**IF GENERALIZED SEIZURE OCCURS:**

1. If falling, assist student to floor, turn to side.
2. Loosen clothing at neck and waist; protect head from injury.
3. Clear away furniture and other objects from area.
4. Have another classroom adult direct students away from area.
5. TIME THE SEIZURE.
6. Allow seizure to run its course; DO NOT restrain or insert anything into student's mouth. Do not try to stop purposeless behavior.
7. During a general or grand mal seizure expect to see pale or bluish discoloration of the skin or lips. Expect to hear noisy breathing.

**IF SMALLER SEIZURE OCCURS** (e.g., lip smacking, behavior outburst, staring, twitching of mouth or hands)

1. Assist student to comfortable, sitting position.
2. Time the seizure.
3. Stay with student, speak gently, and help student get back on task following seizure.

**IF STUDENT EXHIBITS:**

1. Absence of breathing or pulse.
2. Seizure of 10 minutes or greater duration.
3. Two or more consecutive (without a period of consciousness between) seizures which total 10 minutes or greater.
4. Continued unusually pale or bluish skin or lips or noisy breathing after the seizure has stopped.

**INTERVENTION:**

1. Call 911.
2. START CPR for absent breathing or pulse.

**WHEN SEIZURE COMPLETED:**

1. Reorient and assure student.
   a. Assist change into clean clothing if necessary.
   b. Allow student to sleep, as desired, after seizure.
   c. Allow student to eat, as desired, once fully alert and oriented.
2. A student recovering from a generalized seizure may manifest abnormal behavior such as incoherent speech, extreme restlessness, and confusion. This may last from five minutes to hours.
3. Inform parent immediately of seizure via telephone conversation if:
   a. Seizure is different from usual type or frequency or has not occurred at school in past month.
   b. Seizure meets criteria for 911 emergency call.
   c. Student has not returned to "normal self" after 30-60 minutes.
4. Record seizure on Seizure Activity Log.

## If you want additional care given, describe action here:

**If symptoms are** _____

_____

**Give** _____
**(medication/dose/route)**

**Possible side effects** _____

_____

**Physician** Signature _____ Date _____
Print Name _____ Phone _____

☐ I want this plan implemented for my child, _____, in school. I hereby give my permission for exchange of confidential information contained in the record of my child between the nurse and physician and my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

Parent/Guardian Signature: _____ Date: _____

☐ Approved by School Nurse
School Nurse Signature: _____ Date: _____