# Seizure Action Plan

**STUDENT**_____ Birthdate_____ Age_____ Weight_____

School Year_____ School _____ Grade/Teacher/House _____

## MEDICAL HISTORY:

Seizure Type:_____

Description:_____

_____

_____

Last date of seizure: _____ Length of Seizures: _____ Frequency of Seizures: _____

## PRESCRIBED TREATMENT: To be completed by Healthcare Provider

☐ **Use VNS (Vagal Nerve Stimulator) Magnet immediately:**
- Place it over the left chest wall for the count of "one-one thousand, two-one thousand" and remove it.
- Repeat ***every minute*** until seizure stops.

☐ **Give** _____ for seizures lasting more than _____ minutes
(medication name, doses & route)

***OR*** for _____ or more seizures in _____ hour(s).

☒ **9-1-1 shall be called if emergency medication is administered.**

☐ Other_____

**Licensed Prescriber's Name (Please print)** _____ Phone (_____)_____

**Licensed Prescriber's Signature** _____ Date_____

## PARENTAL/GUARDIAN CONSENT:

My Healthcare Provider and I have discussed this Seizure Preparedness Plan. I give my permission for school personnel to follow this Plan and provide appropriate medication administration.

**Parent/Guardian Signature**_____ Date _____

## IF A SEIZURE OCCURS:

1. Confirm seizure as described in Medical History.
2. Provide basic first aid:
   - Clear area of sharp objects.
   - Check time seizure starts & time how long it lasts.
   - Cushion head with something soft & flat. Do ***NOT*** hold down or restrain movements in any way.
   - Turn gently on to side to keep airway clear.
   - Loosen tight clothing
   - Observe what happens during the seizure.
   - Call for adult assistance and notify Health Room Assistant.
   - Keep calm, provide reassurance and privacy.
3. Call Health Room Assistant to immediately call School District Nurse & parent/guardian
4. Call 9-1-1 IF:
   - Seizure behavior is different from other episodes.
   - Coloring or breathing is ***alarmingly*** different than usual.
   - Student is acutely injured during the seizure.
   - emergency medication is administered.

School Nurse Signature: _____ Date:_____