EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 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

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

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2014-2015 Edina Public Schools• Seizure Action Plan

This page to be completed by parent/guardian

Student's Name:_____ **School:**_____

Parent/Guardian Authorization

1. I agree with the above Seizure Action Plan and I request that the above medication/s be given during school hours as ordered by my child's physician/licensed prescriber.
2. I request that the above medication be sent on field trips. ❑ Yes ❑ No
3. I will notify the school if medication is stopped.
4. I give permission for the medication/s to be given by school personnel as delegated, trained, and supervised by the licensed school nurse.
5. Legally I may refuse to sign the Seizure Action Plan. If I refuse to sign, the district will not be able to administer the prescribed medication.
6. This consent may be revoked at any time by sending a written notice to the licensed school nurse.

_____ _____

Parent/Guardian Signature **Date**

Permission for Release of Information

1. I give permission for the school nurse to communicate, as needed with school staff about my child's medical condition/s and the action of the medication/s.
2. I give permission for the licensed school nurse to contact my child's physician/licensed prescriber regarding questions about the above listed medication/s or medical condition/s being treated by medication/s. If I do not give permission, the district may not be able to administer medication.

_____ _____

Parent/Guardian Signature **Date**

Licensed School Nurse _____ Date _____

Health Associate _____ Date _____

For Licensed School Nurse Use

Trained personnel delegated to administer Diastat

1. _____ Date: _____
2. _____ Date: _____

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