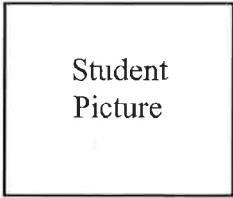


# SEIZURE ACTION PLAN FOR SCHOOL

Student Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ ID # \_\_\_\_\_

School \_\_\_\_\_ Teacher \_\_\_\_\_

Physician \_\_\_\_\_ Phone: \_\_\_\_\_



## EMERGENCY CONTACTS

	<u>Name</u>	<u>Relationship</u>	<u>Home #</u>	<u>Work #</u>	<u>Cell #</u>
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)

<u>MEDICATIONS</u>	<u>AMOUNT TAKEN</u>	<u>HOW OFTEN AND FOR WHAT SIGNS</u>
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.

# STUDENTS WITH SPECIAL HEALTH CARE NEEDS EMERGENCY PLAN NON-MEDICAL STAFF

STUDENT NAME : \_\_\_\_\_ DOB: \_\_\_\_\_ TEACHER: \_\_\_\_\_ RM/GRADE : \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ PREFERRED HOSPITAL: \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_ WORK #: \_\_\_\_\_ CELL #: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_ OTHER PHONE: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ PHYSICIAN TEL: \_\_\_\_\_ PHYSICIAN FAX: \_\_\_\_\_

**STUDENT-SPECIFIC EMERGENCIES**

**IF YOU SEE THIS**

**DO THIS**

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**IF AN EMERGENCY OCCURS:**

1. If the emergency is life-threatening, immediately call 911.
2. Stay with student or designate another adult to do so.
3. Call or designate someone to call the principal and/or school nurse.
  - a. State who you are.
  - b. State where you are.
  - c. State problem.

**DOCUMENTATION OF STAFF TRAINING**

**DATE:**

**TRAINED BY:**

**STAFF NAME:**

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

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