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

Photo of Student Here

Student's Name _____

Date of Birth _____

Parent/Guardian: _____

Phone _____

Cell _____

Other Emergency Contact: _____

Phone _____

Cell _____

Treating Physicians: _____

Address _____

Phone _____

Significant Medical History

_____

_____

_____

_____

_____

_____

_____

_____

_____

SEIZURE INFORMATION

Focal Onset ◯ Generalized Onset ◯ Mixed ◯ Unknown Onset ◯

Seizure Type	Length of Time	Frequency	Description
Seizure Triggers		Student's Response After Seizure	
Warning Signs			

Epilepsy Association
Serving individuals in Northeast Ohio with seizure disorders

www.epilepsyinfo.org
(216) 579-1330
2831 Prospect Ave.
Cleveland, OH 44115

SEIZURE ACTION PLAN

EMERGENCY RESPONSE

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

_____
_____
_____
_____
_____
_____
_____

SEIZURE ACTION PROTOCOL:

Actions to take in the case of a seizure at school

Indicate the numerical order of steps in plan

___ Contact school nurse or other trained staff _____
___ Call 911 for transport to _____
___ Notify parent or emergency contact _____
___ Administer emergency medication as indicated below _____
_____
___ Notify Doctor _____
___ Other_____
_____

TREATMENT PROTOCOL DURING SCHOOL HOURS

MEDICATION	DOSAGE / HOW OFTEN	COMMON SIDE EFFECTS & SPECIAL INSTRUCTIONS

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SEIZURE ACTION PLAN

Additional Instructions:

_____
_____
_____
_____
_____
_____
_____

List other medications taken at home:

_____
_____
_____
_____
_____
_____
_____

Describe any special considerations and precautions
(regarding school activities, sports, trips, etc).

_____
_____
_____
_____

Does student have a VAGUS NERVE STIMULATOR (VNS)? ● YES ● NO

If YES, describe magnet use:

_____
_____
_____
_____

Physician Signature _____ Date _____

Parent/ Guardian Signature _____ Date _____

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General Information

BASIC SEIZURE FIRST AID

- Stay calm and track time
- Do not restrain
- Do not put anything in mouth
- Stay with student until fully conscious
- Record seizure on plan

For Tonic-clonic (grand mal) seizure:

- Protect Head
- Keep airway open/watch breathing
- Turn student on side

A SEIZURE IS GENERALLY CONSIDERED AN EMERGENCY WHEN:

- Convulsive seizure lasts longer than five 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 the water

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the undersigned, authorize _____ (Disclosing Institution) and its employees to release information from my medical records as describes above to the school nurse. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

I understand that I have a right to revoke t his authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department of the treating physician. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one (1) year from date of signature.

I understand that treatment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

As a professional courtesy, no cost is assessed for information released directly to your health care provider.

Revocation of this release still entitles me to all other rights of a student within the _____ (School District).

Parent/ Guardian Signature _____ Date _____

Student Signature (If Applicable) _____ Date _____

Description of Legal Representative's Authority to Act on Behalf of Student (if applicable):

_____

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