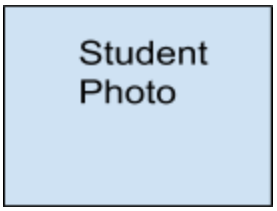

Seizure Action Plan

Student's Name:	**School/Grade:**
Date of Birth:	**Contact Teacher:**
Parent/Guardian Name:	**Phone (Family):**
Address	
Physician:	**RN:**
Emergency Number:	

Seizure Type: _____
Date: _____

Medications:

____ Diastat: ____mg rectally as needed for a seizure lasting more than _____ mins.
Or _____ or more seizures in _____hrs.

____ Versed ____mg intranasally as needed for a seizure lasting more than _____mins.
Or _____ or more seizures in _____hrs.
Additional Directions _____

____ Use VNS (vagal nerve stimulator) magnet _____

____ Other: _____

Signs/Symptoms: _____ staring ____ unresponsiveness ____ confusion ____ jerking or twitches ____ shaking _____ falling _____picking or lip smacking

_____ whole body convulsions (grand mal)

STAY CALM- you <u>cannot</u> stop a seizure · **Note time seizure began (if possible)** · **Keep child safe** · **Call office for RN and give location and name of student** · **Guide child to floor, position student on their left side to keep airway open** · **Do not restrain or attempt to put anything in student's mouth** · **Loosen any tight clothes** · **Remove eyeglasses** · **Move objects/furniture away from child that they may bump** · **Stay with child until help arrives or seizure stops** · **If loss of bowel or bladder control, cover the child for privacy**	**For Staring (Absence or Complex Partial) Seizure:** · **No action needed if brief periods of staring, mumbling, or shaking of arms or legs** · **No action needed if student has brief periods of dazed or zoned out** · **Speak quietly and calmly** · **Guide the student gently away from any possible source of injury** · **Stay with the student until the seizure ends** · **Comfort the student and allow to rest afterward if needed.**

CALL 911 and tell them "a student is having a seizure" if:

- **Seizure lasts longer than _____ minutes.**
- **Child has _____ seizures in _____ minutes.**
- **Child has an injury or severe seizure.**

Action after a seizure:

_____ Permit child to rest in clinic **_____ Permit child to return to class**

_____ Provide a change of clothing as needed **_____ Contact parent/legal guardian**

I am in agreement with this plan of care and understand it will be shared as needed with members of the school staff to safeguard and promote the health of the student listed above while at school. I will notify the school immediately if: 1) the health status of the student listed above changes, 2) we change physicians, or 3) there is a change or cancellation of the physician's orders.

Parent/Legal Guardian _____
Date _____

Registered Nurse _____
Date _____

MEDICAL REVIEW

I have reviewed the attached Seizure Action Plan for _____ AND:

_____ I approve the Action Plan as written.

_____ I approve the Action Plan with the attached amendments.

_____ I do not approve of the Action Plan as written, and substitute orders are attached.

Physician _____
Date _____

Other Recommendations:

Copies to:

☐ Board Office ☐ Bus Garage ☐ Teacher ☐ Other_____