EPILEPSY FOUNDATION®

Seizure Action Plan

Effective Date

This child 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 reaction to seizure(s)

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

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 (grand mal) seizure:

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

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 _____

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 diabetic
- ❒ 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.)

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

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Seizure Observation Record

Student's name:_____

Date & time					
Seizure Length					
Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)					
Conscious (yes/no/altered)					
Injuries (briefly describe)					
Muscle Tone/Body Movements	Rigid/clenching				
	Limp				
	Fell down				
	Rocking				
	Wandering around				
	Whole body jerking				
Extremity Movements	(R) arm jerking				
	(L) arm jerking				
	(R) leg jerking				
	(L) leg jerking				
	Random Movement				
Color	Bluish				
	Pale				
	Flushed				
Eyes	Pupils dilated				
	Turned (R or L)				
	Rolled up				
	Staring or blinking (clarify)				
	Closed				
Mouth	Salivating				
	Chewing				
	Lip smacking				
Verbal Sounds-describe (gagging, talking, throat clearing, etc.)					
Breathing-describe (normal, labored, stopped, noisy)					
Incontinent (urine or feces)					
Post-Seizure Observation	Confused				
	Sleepy/tired				
	Headache				
	Speech slurring				
	Other				
Length to orientation					
Parents notified? (note time of call)					
EMS called? (note call and arrival time)					
Observer's Name					

Please put additional notes on back as necessary.