EMERGENCY ACTION PLAN

Seizures

Student's Name________________________________**DOB**__________**School**_________________

Grade______**Teacher**____________________**Bus #**________**Daycare yes** _____ **no**_____

Parents/Guardians _____________________________________ Phone ____________________

_____________________________________ Phone ____________________

Healthcare Provider __________________________________ Phone ____________________

1. What type of seizures does your child have and how often do they occur?

   ____

2. Describe your child's symptoms during and after the seizure episode.

   ____

   ____

3. Does your child have an aura or warning of a seizure coming? Is she/he able to notify anyone that a seizure is coming?

   ____

4. Name of seizure medications: How often are they taken?

   At home ____

   At school ____

5. Does your child have any side effects from these medications? Please list:

   ____

6. Are there any sports/activities in which your child CANNOT fully participate?

   ____

Parent Signature ____**Date**____________

PLEASE NOTE: If medication is to be taken at school, a medication authorization form must be completed by a parent AND a physician and kept at the school. These forms are obtained from your school office staff or school nurse. These forms are completed on a yearly basis.

PLEASE READ THE EMERENCY ACTION PLAN FOR SEIZURES ON THE REVERSE SIDE AND ADD ANY FURTHER INSTRUCTIONS WE NEED TO BE MADE AWARE OF.

By signing below, the school nurse has your permission to share this Emergency Action Plan with appropriate school personnel.

PARENT/GUARDIAN
SIGNATURE ____ DATE ___________________

EMERGENCY ACTION PLAN

Seizures

____ Student's Name

____ Teacher

What type of seizure does the child have? What are his/her symptoms?

[ ] Petit Mal (absence seizure)

[ ] brief loss of consciousness

[ ] minimal or no alteration in muscle tone

[ ] usually able to maintain postural control

[ ] frequently has minor movements or twitches

[ ] often mistaken for inattention

[ ] stares blankly into space

[ ] Other: _____________________________

[ ] Grand Mal (tonic-clinic seizure)

[ ] loss of consciousness

[ ] child falls to floor or ground

[ ] breathing may stop for a moment

[ ] arms and legs may become rigid and move in rhythm with face

[ ] may be incontinent of urine and/or feces

[ ] may last several minutes

[ ] may want to sleep afterwards

[ ] Other: _____________________

EMERGENCY PLAN:

1) Stay with child during and after seizure. Note duration of seizure and type of body movements.
2) Clear area around student to prevent injury.
3) Assist to horizontal position if loss of consciousness occurs. Remove student's glasses, loosen clothing around neck.
4) Turn on side as soon as able.
5) DO NOT RESTRAIN MOVEMENT OR PLACE ANYTHING IN MOUTH.
6) Monitor breathing and begin artificial respiration if breathing does not resume spontaneously.
7) If seizure lasts more than 5 minutes or student has one seizure after another without waking, call 911 and transport to __________________Hospital.
8) When seizure is over, allow child to rest and always notify parents.
9) Notify school nurse if she is in the building.
10) Emergency Medication Order (if applicable): _______________________________________
    ____
11) Other instructions: ____
    ____

Parent/Guardian Signature____**Date**_______________

Nurse Signature____ **Date** ______________