SCHOOL SEIZURE ACTION PLAN FOR

_____ (INSERT NAME HERE)

Attach Student Photo

ABOUT

Name _____ Date of Birth _____

Doctors Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Seizure Type/Name: _____

What Happens: _____

How Long It Lasts: _____

How Often: _____

Seizure Triggers:

☐ Missed Medicine ☐ Emotional Stress ☐ Alcohol/Drugs ☐ Menstrual Cycle ☐ Missing meals

☐ Lack of Sleep ☐ Physical Stress ☐ Flashing Lights ☐ Illness with high fever

☐ Response to specific food, or excess caffeine Specify: _____ ☐ Other Specify: _____

DAILY TREATMENT PLAN

Seizure Medicine(s)

Name	How Much	How Often/When

Additional Treatment/Care: (i.e.: diet, sleep, devices etc.)

CAUTION–STEP UP TREATMENT

Symptoms that signal a seizure may be coming on and additional treatment may be needed:

☐ Headache ☐ Staring Spells ☐ Confusion ☐ Dizziness ☐ Change in Vision/Auras

☐ Sudden Feeling of Fear or Anxiety ☐ Other Specify: _____

Additional Treatment:

☐ Continue Daily Treatment Plan

- If missed medicine, give prescribed dose from above ASAP.
- Do not give a double dose or give meds closer than 6 hours apart.

☐ Change to: _____ How Much: _____ How Often/When: _____

☐ Add: _____ How Much: _____ How Often/When: _____

☐ Other Treatments/Care: (i.e.: sleep, devices): _____

SCHOOL SEIZURE ACTION PLAN

DANGER–GET HELP NOW

Follow Seizure First Aid Below

☐ Contact School Nurse or Adult trained on rescue medication:
Name: _____ Number: _____

☐ Record Duration and time of each seizure(s)

☐ Call 911 if:

- Student has a convulsive seizures lasting more than ___ minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student is having breathing difficulty

When EMS arrives, a medical provider will perform an individual assessment to determine appropriate next steps.

Rescue Therapy:

☐ Rescue therapy provided according to physician's order:

_____

_____

POST SEIZURE RECOVERY

Typical Behaviors/Needs After Seizure:

☐ Headache ☐ Drowsiness/Sleep ☐ Nausea ☐ Aggression ☐ Confusion/Wandering ☐ Blank Staring
☐ Other Specify: _____

Reviewed/Approved by:

_____
Physician Signature Date

_____
Parent/Guardian Signature Date

SEIZURE FIRST AID

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LEARN MORE AND GET A DOWNLOADABLE VERSION OF THIS ACTION PLAN AT:

Child Neurology FOUNDATION
Creating a Community of Support
childneurologyfoundation.org/sudep

Danny Did® FOUNDATION
dannydid.org

EPILEPSY FOUNDATION
SUDEP INSTITUTE
epilepsy.com/sudep-institute