SCHOOL SEIZURE ACTION PLAN FOR

______________________________ (INSERT NAME HERE)

Attach Student Photo

ABOUT

Name ______________________________ Date of Birth ______________

Doctor's Name (Primary physician to call when seizure occurs) ______________ Phone ______________

Emergency Contact Name ______________________________ Phone ______________

Emergency Contact Name ______________________________ Phone ______________

Seizure Type(s) / Name(s): ______________________________

What Happens: ______________________________

How Long It Lasts: ______________________________

How Often: ______________________________

Seizure Triggers*:

**If multiple seizure types, consider talking to your school about additional details they may need to know.*

- ☐ 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: ______________

DANGER – GET HELP NOW

☐ 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

Other reasons to call 911: ______________________________

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:

☐ Preferred hospital: ______________________________

SCHOOL SEIZURE ACTION PLAN

DAILY TREATMENT PLAN

Seizure Medicine(s) *(Ensure school has full prescription instructions.)*

Name	How Much	How Often/When
Additional Treatment/Care: (i.e.: diet, sleep, devices etc.)		

CAUTION–STEP UP TREATMENT

Some symptoms can signal that a seizure may be coming on. __________ has the following symptoms as warning sign for an impending seizure and may need additional treatment

☐ 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, safe position): ____

POST SEIZURE RECOVERY

Typical Behaviors/Needs After Seizure:

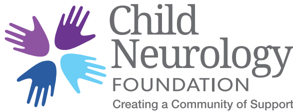
☐ Headache ☐ Drowsiness/Sleep ☐ Nausea ☐ Aggression ☐ Confusion/Wandering ☐ Blank Staring
☐ Other Specify: ______________

Reviewed/Approved by:

____
Physician Signature Date

____
Parent/Guardian Signature Date

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



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