



SEIZURE EMERGENCY ACTION PLAN

Name: _____ DOB: _____
 Student ID: _____ School: _____ Grade: _____
 Parent/Guardian: _____ Phone: _____
 School Nurse: _____ Phone: _____

**PLACE
PICTURE
HERE**

HEALTHCARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:

Seizure Type(s): _____
 Seizure Symptom(s): _____
 Duration: _____ Frequency: _____ Triggers: _____
 Accommodations (re: school related activities, trips, parties, sports, etc.): _____

Is rescue medication ordered*? No Yes, Name: _____ Dose: _____
 Route: _____ When to give rescue med: _____

Student has**: VNS RNS DBS None Location of Magnet: _____

Student ability to manage and understand their epilepsy/seizure disorder: (choose one)

Novice Beginner Competent Proficient Expert

*CHN25 required for all medications **CHN04 required

HOW TO RESPOND TO A SEIZURE



- Remain calm and begin timing seizure
- Keep student safe: remove harmful objects, don't restrain, protect head
- Turn on side, keep airway clear, don't put objects in mouth
- Give rescue medication if ordered
- Stay with student until recovered from seizure
- Notify emergency contact and school nurse



**EMERGENCY
CALL 911**

- Seizure with loss of consciousness longer than 5 minutes
- Repeated seizures longer than 10 minutes, no recovery between seizures
- Difficulty breathing after seizure
- Serious injury occurs or suspected
- Seizure occurs in water
- Not responding to rescue medication if available



CARE AFTER SEIZURE:

- What type of help is needed? _____
- When may the student resume usual activity? _____

Healthcare Provider Signature: _____ Date: _____

Print Provider Name: _____ Phone: _____

I approve this emergency action plan and give permission for this plan to be shared with school personnel that will be in contact with my student. I also give permission for the school nurse to contact the healthcare provider listed on this plan as needed in the care of my student.

Parent/Guardian Signature: _____ Date: _____