Emergency Seizure Action Plan for the Classroom

Name ____________________________DOB _______________ Allergies ______________________________

School Year_________________ **Specific information for this student:** Seizure Type _______________________________ Usual Length of Seizure ______________________ Usual symptoms of seizure: Seizure triggers or warning signs: Student's response after a seizure: Other information:	**BASIC SEIZURE FIRST AID:** ➢ Stay calm, stay with the student & time seizure ➢ Keep student safe ➢ Stay with the child until fully conscious/until emergency personnel or school nurse arrives ➢ Record seizure in the log ➢ Do NOT restrain & DO NOT put anything in mouth <u>For tonic-clonic (grand mal) seizure:</u> ➢ Protect head – loosen restrictive clothing ➢ Keep airway open, watch breathing ➢ Turn child on side, provide privacy ➢ Move tables, desks, chairs away from student
A seizure emergency for this student is defined as: **Seizure Emergency Protocol:** ➢ Call 911 ➢ Check for breathing & pulse, if absent, begin CPR ➢ Contact the school nurse at ________________ ➢ Notify parent/guardian or emergency contact	**A Seizure is considered an EMERGENCY when:** ➢ A seizure lasts longer than 5 minutes ➢ Student has repeated seizures without regaining consciousness ➢ Student is injured or diabetic ➢ Student has breathing difficulties ➢ Student has a seizure in the water ➢ Student is not breathing or has no pulse

EMERGENCY SEIZURE MEDICATION/ TREATMENT INSTRUCTIONS

Treatment/Medication______________________ Dose _________ How to administer ___________________
When to give medication: ____

This treatment/medication can be administered by: ☐ School Nurse ☐ _______________________________

EMERGENCY CONTACT INFORMATION:

Physician Name____Phone:______________________________
Parent/Guardian Name: ______________________________________ Phone: _______________ Cell: __________
Parent/Guardian Name: ______________________________________ Phone: _______________ Cell:___________
Other Emergency Contact: ____________________________________Phone: ______________________________

I give permission for school personnel to share this information, follow this plan, administer medication, care for my child and, if necessary, contact our healthcare provider. I assume full responsibility for providing the school with prescribed medication and devices. I approve this Seizure Emergency Care Plan for my Child.

Signature of Parent/Guardian: ____ Date: ________________

Information for this document taken from publicly available CDC and Epilepsy websites.