

CONTACT INFORMATION:

Student's Name: _____ School Year: _____
 School: _____ Grade: _____ Classroom: _____
 Parent/Guardian Name: _____ Tel. (H): _____ (W): _____ (C): _____
 Other Emergency Contact: _____ Tel. (H): _____ (W): _____ (C): _____
 Child's Neurologist: _____ Tel: _____ Location: _____
 Child's Primary Care Dr.: _____ Tel: _____ Location: _____
 Significant medical history or conditions: _____

SEIZURE INFORMATION:

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>

Seizure triggers or warning signs: _____

Response after a seizure: _____

TREATMENT PROTOCOL: (include daily and emergency medications)

<i>Medication</i>	<i>Emergency Med?</i>	<i>Dosage & Time of Day Given</i>	<i>Route of Administration</i>	<i>Common Side Effects & Special Instructions</i>
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			

Does child have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, describe magnet use _____

BASIC FIRST AID, CARE & COMFORT:

Please describe basic first aid procedures: _____

Does person need to leave the room/area after a seizure? YES NO

If YES, describe process for returning: _____

Basic seizure first aid:

- Stay calm & track time
- Keep person safe
- Do not restrain
- Do not put anything in mouth
- Stay with person until fully conscious
- Record seizure in log

For tonic-clonic (grand mal) seizure:

- Protect head
- Keep airway open/watch breathing
- Turn person on side

EMERGENCY RESPONSE:

A "seizure emergency" for this person is defined as: _____

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- Call 911 for transport to _____
- Notify parent or emergency contact
- Notify doctor
- Administer emergency medications as indicated below
- Other _____

A seizure is considered an emergency when:

- A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- There are repeated seizures without regaining consciousness
- It's a first-time seizure
- The person is injured or has diabetes
- The person has breathing difficulties
- The seizure is in water

SEIZURE INFORMATION:

1. When was your child diagnosed with epilepsy? _____
2. How often does your child have a seizure? _____
3. Has there been any recent change in your child's seizure patterns? YES NO
If YES, please explain: _____
4. How do other illnesses affect your child's seizure control? _____
5. What should be done when your child misses a dose? _____
(Refer to physician care plan)

SPECIAL CONSIDERATIONS & PRECAUTIONS:

Check any special considerations related to your child's epilepsy while at school. *(Check appropriate boxes and describe the impact of your child's seizures or treatment regimen)*

- | | |
|--|---|
| <input type="checkbox"/> General health: | <input type="checkbox"/> Physical education (gym)/sports: |
| <input type="checkbox"/> Physical functioning: | <input type="checkbox"/> Recess: |
| <input type="checkbox"/> Learning: | <input type="checkbox"/> Field trips: |
| <input type="checkbox"/> Behavior: | <input type="checkbox"/> Bus transportation: |
| <input type="checkbox"/> Mood/coping: | |
| <input type="checkbox"/> Other: _____ | |

GENERAL COMMUNICATION ISSUES:

What is the best way for us to communicate about your child's seizure(s)?: _____

Does school personnel have permission to contact your child's physician? YES NO

Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent Signature: _____ Date: _____ Dates Updated _____, _____

Physician Signature: _____ Date: _____

Once this Seizure Action Plan has been filled out, take a copy for the school nurse to keep.

Visit EFMN.ORG for additional resources.