Student Photo

School Year __/__

Slippery Rock School District
Seizure Action Plan
Must be completed each school year

Student Name:_____ DOB: _____Grade____ Room#_____

Seizure Information:

Seizure Type	Length	Frequency	Description

Significant Medical History: _____
Seizure triggers or warning signs:_____
Student's reaction to seizures:_____

BASIC FIRST AID: COMFORT AND CARE	**When is a Seizure generally considered an Emergency**
• Stay calm and track time • Keep child safe • Do not restrain • Do not put anything in mouth • Stay with child until fully conscious • Record seizure in log **For tonic –clonic(grand mal) seizure:** • Protect head • Keep airway open/watch breathing • Turn child on side	• A convulsive (tonic-clonic) seizure lasts longer than 5 minutes • Student repeated seizures without regaining consciousness • Student has a first time seizure • Student is injured or has diabetes • Student has breathing difficulties • Student has a seizure in water

If basic first aid procedure is different than above, describe: _____
If a "seizure emergency is different than above, describe: _____

Does student need to leave the classroom after a seizure? (Circle) No Yes, if yes, describe process for returning student to classroom_____

Seizure Emergency protocol: Check all that apply and clarify if needed
____Contact Nurse at _____
____Call 911 for transport to closest medical facility
____ Notify Parent or Emergency contact
____ Notify Doctor at_____
____ Administer emergency medication

Medications			
Medication	**Dosage and Time of Day Given**	**Common Side Effects and Special Instructions**	**Check if and Emergency Medication**

Does the student have a **Vagus Nerve Stimulator**? (Circle) NO YES if yes, Describe magnet use _____

SPECIAL CONSIDERATIONS AND SAFETY PRECAUTIONS (REGARDING SCHOOL ACITIVIES, SPORTS, TRIPS, ECT)_____

Contact Information

Name: _____ Phone Numbers:_____
Emergency Contact/phone number: _____
Plan prepared by:
Doctor:_____ Signature: _____Date:_____ Office Number:_____

(Required)

I give my permission for the school nurse to use the information provided to share with Slippery Rock School District personnel and for the nurse to contact my child's physician listed above to discuss my child's condition as needed.

Parent's Signature _____Date:_____

(Required)