

SEIZURE ACTION PLAN

Effective Date:	

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name:				Date of Birt	h:		
Parent/Guardian:					Cell:		
Treating Physician:_							
Significant medical h							
SEIZURE					Dogovintion		
Seizure Type	Lengin	Frequency			Description		
	1						
	+						
	<u> I </u>	l					
Student's reaction to	seizures:						
BASIC FIRST AID: Does student need treturning student to	o leave the				<u>, </u>	Stay with chi	track time afe ain nything in mouth lild until fully conscious
크에크(연크 NGY R로) A "seizure emergend		student is defin	ed as:			Protect head	(grand mal) seizure: d open/watch breathing
Seizure Emergency ☐ Contact school nu ☐ Call 911 for trans ☐ Notify parent or e ☐ Notify doctor	urse at: <u>ext</u> port to	2118	· · · · · · · · · · · · · · · · · · ·			A convulsin setzure las minutes Student ha	penerally considered y when: we (tonic-clonic) ts longer than 5 s repeated seizures paining consciousness
□ Administer emerg□ Other	•					Student ha Student is Student ha	s a first time seizure injured or is diabetic s breathing difficulties s a seizure in water
TREATMENT PROT	OCOL DU	RING SCHOOL	L HOURS: (include dail	y and emergency	Person is p	regnant
medications) Emergency medi	cation & Dai	ly Medication	_	& Time of Day Given	Common Side Effects & Special Instructions	k	
Does student have a If YES, Describe mag					L		
SPECIAL	CONSIDER	RATIONS & SA	FETY PRE	CAUTIONS:	(regarding school act	ivities, sports, trip	os, etc.)
Physician Signature:					Date:		
Parent Signature:							
Paviawad by:					Date:		