SEIZURE ACTION PLAN FOR SCHOOL

Student Name_____D.O.B._____ ID # _____

School _____Teacher_____

Physician _____ Phone: _____

Student Picture

EMERGENCY CONTACTS

Name	Relationship	Home #	Work #	Cell #
1.				
2.				
3.				

Type of seizure: _____

What does the seizure look like and how long does it usually last?_____

_____

Possible triggers that should be avoided: _____

_____

Does student need any special activity adaptations/protective equipment (e.g., helmet) at school?

_____No _____Yes (explain)_____

_____

Is student allowed to participate in physical education and other activities? _____No _____Yes (explain)

_____

ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES? _____No _____Yes (List below the medications needed)

MEDICATIONS	AMOUNT TAKEN	HOW OFTEN AND FOR WHAT SIGNS
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

List medication needed at school (name, dosage/route, and frequency) _____

_____

Possible side effects that must be reported to parent or physician: _____

_____

IF GENERALIZED SEIZURE OCCURS:

1. If falling, assist student to floor, turn to side.
2. Loosen clothing at neck and waist; protect head from injury.
3. Clear away furniture and other objects from area.
4. Have another classroom adult direct students away from area.
5. TIME THE SEIZURE.
6. Allow seizure to run its course; DO NOT restrain or insert anything into student's mouth. Do not try to stop purposeless behavior.
7. During a general or grand mal seizure expect to see pale or bluish discoloration of the skin or lips. Expect to hear noisy breathing.