SEIZURE ACTION PLAN

Student Name: ____________________

Contact Immediately After a Seizure

School Nurse Name: ____________________ Phone Number: ____________________

(Or other designated individual on-site all school day)

General Information

School Name: ____________________ School Year: __________ Student Grade Level: ______

Classroom(s): ____________________

Parent/Guardian Name: ____________________

Primary Phone: ____________________ Secondary Phone: ____________________

Other Emergency Contact: ____________________

Primary Phone: ____________________ Secondary Phone: ____________________

Child's Neurologist: ____________________

Phone: ____________________ Location/Clinic: ____________________

Child's Primary Care Dr: ____________________

Phone: ____________________ Location/Clinic: ____________________

What's the best way to communicate with you about your child's seizures? ____________________

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

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

Seizure Information

Seizure Type/Name	Length	Frequency	Description

Seizure Triggers/Warning Signs: ____________________

Medication/Treatment Protocol

Medication Name	Emergency Med?	Dosage & Time Given	Administration Method	Common Side Effects/ Special Instructions

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

If yes, describe magnet use: ____________________

Seizure First Aid/Proper Response

Respond to a seizure by: ____

____

Do they need to leave the room/area after a seizure? YES NO

If yes, describe the process for returning: ______________________________

Emergency Response

A “seizure emergency” for your child is defined as: _____

____

Seizure Emergency Protocol Includes:

- ☐ Call 911 for transport to: ______________________
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medication indicated on front page
- ☐ Other: ____

General Seizure Information

How often does your child have seizures? ____________________

Has there been any recent changes in their seizure pattern? YES NO

If yes, please explain: ______________________________________

What should be done if your child misses a medication dose? ______________________

Should the school have backup medication available if they miss a dose? YES NO

Do you wish to be called before backup medication is given for a missed does? YES NO

Special Considerations/Precautions

Note any special considerations related to your child's epilepsy while at school:

- ☐ General Health: ____________________
- ☐ Physical Functioning: ____________________
- ☐ Learning: ____________________
- ☐ Behavior: ____________________
- ☐ Physical Education(Gym): ____________________
- ☐ Recess: ____________________
- ☐ Field Trips: ____________________
- ☐ Bus Transportation: ____________________
- ☐ Mood/Coping: ____
- ☐ Other: ____

Parent Signature: ____________________ Date: ____________ Dates Updated: ________

Physician Signature: ____________________ Date: ____________

For additional epilepsy and seizure information, contact the Epilepsy Foundation of Minnesota at info@efmn.org or 651.287.2300.