

## Seizure Action Plan & Medical Alert Information

**Instructions:** This form is a communication tool for use by parents to share information with the school. Update form yearly or if any changes in condition and/or treatment.

**School Year:** \_\_\_\_\_ **Date of Plan:** \_\_\_\_\_

Name of Student:		Date of Birth:	Care Card Number:
School:	Grade:	Teacher/Div:	Date of Plan:
<b>CONTACT INFORMATION</b>			
<b>Parent/Guardian 1:</b>	Name:		<input type="checkbox"/> <b>Call First</b>
	Cell Number:	Work Number:	Home Number:
		Other Number:	
<b>Parent/Guardian 2:</b>	Name:		<input type="checkbox"/> <b>Call First</b>
	Cell Number:	Work Number:	Home Number:
		Other Number:	
<b>Other/Emergency:</b>	Name:		Relationship:
	Able to advise on seizure care: <input type="checkbox"/> Yes <input type="checkbox"/> No		Home Number:
		Work Number:	
Neurologist:	Phone Number:	Family Physician:	Phone Number:

### GENERAL COMMUNICATION:

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

Significant medical history or condition:

### SEIZURE INFORMATION:

1. When was your child diagnosed with seizures or epilepsy?

2. Seizure type(s):

3. What time of day do seizures occur?

4. How long do the seizures last?

5. How often do seizures occur?

6. Description of seizure:

7. Does your child have cluster seizures?

8. Are there any warnings and/or behavior changes before the seizure occurs?

YES  NO If yes, please explain:

9. When was your child's last seizure?

10. How does your child react after a seizure is over?

11. How do other illnesses affect your child's seizure control?

## BASIC FIRST AID: Care and comfort Measures:

12. What basic first aid procedures should be taken when your child has a seizure in school?

13. Will your child need to leave the classroom after a seizure?

YES  NO

14. Does your child need to lie down after a seizure?

YES  NO What process would you recommend for returning your child to classroom?

### Basic Seizure First Aid:

- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure
- ✓ inform parent
- ✓ For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side if ambulatory  
OR if in wheelchair/stander/walker  
child may remain in mobility  
device.

*Note: They may need to be taken out of a mobility device at the end of the seizure if airway is blocked or they want to sleep.*

## SEIZURE EMERGENCIES

15. When does the school call 911?

16. When does the school call the parent?

17. Has your child ever been hospitalized for continuous seizures?

YES  NO If YES, please explain:

### A Seizure is considered an Emergency.

#### CALL 911 WHEN:

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
  - ✓ Student has repeated seizures without regaining consciousness
  - ✓ Student has a first time seizure
  - ✓ Student is injured or diabetic
  - ✓ Student has breathing difficulties after the seizure
  - ✓ Student has a seizure under water
- Serious injury occurs

## Seizure Action Plan & Medical Alert Information

### SEIZURE MEDICATION AND TREATMENT INFORMATION (Physician to Complete)

#### 18. Scheduled medication(s)

Medication	Dosage	Date Started	Frequency and time of day taken	Possible side effects

#### 19. Emergency medications

Medication	Dosage	Administration Instructions (timing & method)	What to do after administration

Have emergency supplies been provided in the event of a natural disaster?

YES    NO   If YES, location of supplies?

20. Does your child have a Vagus Nerve Stimulator?

YES    NO   If YES, please describe instructions for appropriate magnet use:

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### SPECIAL CONSIDERATION & PRECAUTIONS

Check all that apply and describe any considerations or precautions that should be taken

- |  |   |
|--|---|
| <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"/> Playground Equipment: _____            |
| <input type="checkbox"/> Stairs: _____               | <input type="checkbox"/> Other: _____                           |

21. Can this information be shared with classroom teacher(s) and other appropriate school personnel?

YES    NO

Parent/Guardian Signature: \_\_\_\_\_

School Administrator \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_