SEIZURE ACTION PLAN

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

STUDENT NAME:_____ **D.O.B.:**_____ **GRADE:**_____

STREET:_____ **CITY:**_____ **ZIP:**_____

TREATING PHYSICIAN_____ **PHONE:**_____

Primary Contact	**Secondary Contact**
Parent/Guardian Name:_____	Name:_____
Phone #: Cell:_____	Relation:_____
Home:_____	Phone #: Cell:_____
Work:_____	Home:_____
	Work:_____

SEIZURE INFORMATION

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:	Student's response after a seizure:
BASIC FIRST AID: CARE & COMFORT	BASIC SEIZURE FIRST AID
Please describe basic first aid procedures: Does student need to leave the classroom after a seizure? _____Yes _____No	• Stay calm & track time • Keep child safe • Do NOT restrain • Do NOT put anything in mouth • Stay with child until fully conscious • Record seizure in log

<table>
<tr><td>If YES, describe process for returning student to classroom</td><td>BASIC SEIZURE FIRST AID</td></tr>
<tr><td>Date/severity of last seizure:</td><td>For Tonic-Clonic Seizures

• Protect head
• Keep airway open/watch breathing
• Turn child on side</td></tr>
<tr><td colspan="2">Emergency Response</td></tr>
<tr><td>A "seizure emergency" for this student is defined as:
_____
_____
_____
_____
_____</td><td>Seizure Emergency Protocol

(Check all that apply and clarify below)
☐ Contact school nurse at ext 1110
☐ Call 911 for transport to Wooster or Dunlap Hospital
☐ Notify parent or emergency contact
☐ Administer emergency medications as indicated below
☐ Notify doctor
☐ Other_____</td><td>A SEIZURE IS GENERALLY CONSIDERED AN EMERGENCY WHEN:

• Convulsive (tonic-clonic) seizure lasts longer than five (5) minutes
• Student has repeated seizures without regaining consciousness
• Student is injured or has diabetes
• Student has a first-time seizure
• Student has breathing difficulties
• Student has a seizure in water</td></tr>
</table>

<table>
<tr><td colspan="4">Treatment Protocol During School Hours/Field Trips (Include Daily and Emergency Medications)</td></tr>
<tr><td>Put an X for Emerg. Med.</td><td>Medication</td><td>Dosage & Time of Day Given</td><td>Common Side Effects & Special Instructions</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
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<tr><td colspan="4">Special Considerations and Precautions (Regarding School Activities, Sports, Trips, Etc.)</td></tr>
</table>

AGREEMENT:

- I am requesting permission for my child named above to receive medication in accordance with this action plan. I will assume responsibility for safe delivery of the medication/drug to school. The medication but be brought to school in the container in which it was dispensed by the prescriber or licensed pharmacist.

- I will notify the school immediately if there is any change in the use of the medication or prescribed treatment. A revised action plan will need to be on file signed by the prescriber.

- I release and agree to hold the Board of Education, it's officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization

SIGNATURES: Represent agreement with the above information and action plan

PARENT/GUARDIAN:_____**DATE:**_____

LICENSED PRESCRIBER:_____**DATE:**_____

SCHOOL NURSE:_____**DATE:**_____

5/10
4/4/14