



MEMBER ORGANIZATION OF
Epilepsy Alliance America

Seizure Action Plan

Individuals with a seizure action plan are being treated for a seizure disorder. This information is to assist school personnel with providing care should a seizure occur during school hours or school sanctioned activities.

Student Name:	Date of Birth:	Effective Date:
Parent/Guardian	Preferred phone number:	Cell Phone:
Other Emergency Contact	Preferred phone number:	Cell Phone:

Medical Provider and Medical History

Treating Physician Name:	Phone number:	Hospital associated with Physician
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Important Medical History/Information:

Seizure History

Seizure triggers/warning signs		Student response after seizures	
Seizure Type	Length of Seizure	Frequency	Description of Seizure

Seizure First Aid, Comfort and Care for student

Description of what can be done for student when a seizure occurs:

Special Instructions of student's teacher if the seizure occurs within the classroom:

Medication Management/Treatment during school hours

Medication Name	Dosage and Time of day Given	Side effects to look out for and special instructions	Emergency Med

Vagus Nerve Stimulator

Does the Student have a Vagus Nerve Stimulator: Yes _____ No _____

If yes, what are the Magnet Instructions:

Emergency Response

When is a seizure considered an "emergency" for this student:	Seizure Emergency Protocol: Select all that apply
	<input type="checkbox"/> Contact school Nurse at _____
	<input type="checkbox"/> Contact 911 for transport to _____
	<input type="checkbox"/> Notify parents or emergency contact
	<input type="checkbox"/> Administer emergency medications as indicated above
	<input type="checkbox"/> Notify doctor
	<input type="checkbox"/> Other _____

Special considerations or precautions regarding school activities: (Sports, Field Trips, Activities)

Describe and special considerations or precautions:

Physician Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____