SEIZURE ACTION PLAN

School Name:	**Today's Date:**
Student Name:	**DOB:**
Parent/Guardian:	**Phone #'s:**
Physician Name:	**Physician Office / FAX#**

Seizure Specifics:

Aura: ☐ Yes ☐ No Describe:

_____

Date of last documented seizure per parent:_____

When student is off campus or nurse is not available:

- **CALL 911 If seizure lasts longer than 5 minutes or has more than one seizure or is not breathing** *(*see orders below)*
- Notify Parent
- Allow student to rest after seizure
- ☐_____

First Aid for Seizures:

- Stay Calm
- Stay with student during seizure and until fully conscious
- DO NOT restrain movement
- DO NOT place anything in the mouth
- Clear area of potential hazards
- Protect the head
- Time the seizure from beginning to end
- Note movement during seizure
- **If seizure lasts longer than 5 minutes** *(*see orders below)* **or has more than one seizure or is not breathing CALL 911.**

- **After the Seizure:**
  1. Turn student gently to one side. (it is not uncommon for student to vomit/defecate or urinate)

     In the unlikely event that a person does not start breathing after the seizure-start rescue breathing and check for pulse. If no pulse, start CPR
     Wait for assistance and call parent

Types of Seizures

- **Partial**
  Student may not lose consciousness but may have a change in consciousness and may appear dazed, confused, or unaware of their surroundings. Student may exhibit symptoms such as: sudden jerking of one part of body, weakness of arm/leg, sudden fear, facial movements, repetitive movements, nausea, vomiting, and disturbances in vision, hearing, or smell.
- **Absence** (e.g. petit mal)
  Are lapses of awareness, sometimes with staring, that often begin and end abruptly, lasting only a few seconds. There is no warning and no after-effect.
- **Tonic – clonic** (e.g. grand mal)
  Student will lose consciousness; body will become rigid with jerking and thrashing movements which may last several minutes. Student may be incontinent of urine and feces and usually wants to sleep after seizure.

PROVIDER ORDERS:

Type of seizure: ☐ Tonic-Clonic ☐ Absence ☐ Partial ☐ Other _____

Usual length of seizure: _____

Seizure Triggers: ☐Strobe lights/Emergency lights ☐ Loud repetitive noise ☐ Anxiety/Anger
☐Missed medication ☐ Computer Monitor/TV screen ☐ Other _____

Additional Information: _____

Medication (routine)	Dose	Route	Administration Time
1.			
2.			
Emergency Medication			☐ Seizure lasting _____ minutes or longer ☐ Cluster of seizures: _____ seizures in _____ minutes

Vagal Nerve Stimulator: ☐ Yes ☐ No Stimulator Site _____ Magnet Location:_____

PE or activity restrictions: ☐ Yes ☐ No If yes, please list:_____

Activate 911:
☐ *Seizure Activity lasts > than _____ minutes
☐ Unresponsive after _____ minutes of emergency med admin
☐ Seizure continues > _____ minutes after emergency med admin
☐ Other_____

Provider's Signature_____ **Date:** _____

I give my permission for the school nurse and trained school personnel to follow this plan and contact my provider, if necessary. I assume full responsibility for providing the school with the prescribed medications and equipment. I give my permission for the school to share the above information with school staff that need to know. I authorize appropriate transport and medical care for my child.

Parent / Guardian Signature: _____ **Date:** _____

School RN Signature: _____ **Date:** _____

Nursing Diagnoses: Mobility: physical, impaired; Communication, impaired verbal; Sensory perception disturbed; Injury, risk for
NIC - Prevention or minimization of potential injuries NOC - Neurological Status: Ability to coordinate CNS activity for safe movement and control

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