EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

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

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

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 in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 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

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

DPC772

Seizure Treatment Plan with Diastat

Student Name: _____

Treatment Order Date: _____

Age: _____ Weight: _____

Treatment:

- DIASTAT® ACUDIAL™ (diazepam rectal gel) _____ mg rectally prn for:

  Seizure > _____ minutes OR for _____ or more seizures in _____hours

- **OTHER**: _____

  _____

- **Call 911 if**:
  - Seizure does not stop within _____minutes of giving DIASTAT ACUDICAL.
  - Child does not start waking up within _____ minutes after seizure is over (no DIASTAT ACUDIAL given).
  - Child does not start waking up within _____ minutes after seizure is over (after DIASTAT ACUDIAL given).

Following a seizure:

_____ Child will return to class.

_____ Child should rest in the nurse's office.

_____ Parents/caregiver should be notified immediately.

_____ Parents/caregiver should receive a note/copy of the seizure report sent home with child.

Physician/Nurse Practitioner (Printed): _____

Signature: _____ Date: _____

Address: _____

Phone: _____