411 East Chestnut Street, Charleston, MS 38921
662-647-5524 | Fax 662-647-3720
www.etsd.k12.ms.us

INDIVIDUAL SEIZURE ACTION PLAN

HEALTHCARE PROVIDER AND PARENT/GUARDIAN SIGNATURES REQUIRED

Student	_____ DOB: _____
School/grade/teacher	_____
Parent/guardian	_____ Phone: _____
Emergency contact	_____ Phone: _____
Treating provider	_____ Phone: _____
Plan effective	From: _____ Through: _____

SEIZURE PROFILE

Type	Usual duration	Usual frequency	What it looks like / student response

Triggers/warning signs	_____
After-seizure needs	☐ Rest ☐ Quiet area ☐ Parent contact ☐ Return to class when alert ☐ Other: _____
Leave classroom?	☐ No ☐ Yes - Location/process: _____
VNS/RNS/device	☐ No ☐ Yes - Instructions: _____

FIRST AID - ALL SEIZURES

☐ Stay calm, remain with the student, and time the seizure.
☐ Protect from injury; clear nearby hazards; cushion the head if needed.
☐ Do not restrain movement and do not place anything in the mouth.
☐ For a convulsive seizure, turn the student on the side when safely possible and monitor breathing.
☐ Do not give food, drink, or oral medication until fully alert and able to swallow.
☐ Follow this plan, administer rescue medication if ordered, document the event, and notify as directed.

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Seizure Action Plan

EMERGENCY DEFINITION AND RESPONSE

☐ Call 911 if a convulsive seizure lasts 5 minutes or longer, unless the provider specifies a shorter threshold below.

☐ Call 911 for repeated seizures without recovery, breathing difficulty, serious injury, seizure in water, first known seizure, or another emergency defined below.

☐ Administer prescribed rescue medication according to the order and training.

☐ Notify parent/guardian and school nurse/administrator.

☐ Send a copy of the action plan and medication record with EMS when feasible.

For this student, a seizure emergency is defined as

Rescue medication	_____
Dose/route	_____
Give when	_____
May repeat	☐ No ☐ Yes - After _____ minutes; maximum _____ dose(s)
After giving	☐ Call 911 ☐ Call parent ☐ Call provider ☐ Other: _____
Storage/self-carry	_____

DAILY MEDICATION AND SCHOOL ACCOMMODATIONS

Medication	Dose/route	Time	Side effects / instructions

Activity, transportation, field trip, testing, or safety precautions

_____
Healthcare Provider Signature / Date

_____
Parent/Guardian Signature / Date

_____
School Nurse/Designee Review / Date

_____
School Administrator Review / Date

RENEWAL This plan should be reviewed at least annually and whenever the student's condition, medication, or emergency instructions change.