



SEAMAN USD #345 SEIZURE EMERGENCY ACTION PLAN

This student is being treated for a seizure disorder. The information below should be completed by the student's medical care provider to assist the school nurse with planning of care for seizure management during the school day.

Student Name:	Date of Birth:
Parent/Guardian Name:	Phone: H - W - C-
Other Emergency Contact:	Phone: H - W - C-
Physician:	Phone:
Significant Medical History:	Other:

Seizure Information:

Seizure Type	Length	Frequency	Description

Seizure Triggers or Warning Signs (Auras);

Basic First Aid/Comfort Measures: (Please check all that apply.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Stay calm & track time | <input type="checkbox"/> Keep child safe | <input type="checkbox"/> Do not restrain |
| <input type="checkbox"/> Do not put anything into mouth | <input type="checkbox"/> Stay with child until fully conscious | |
| <input type="checkbox"/> Document on seizure log | <input type="checkbox"/> Protect head | <input type="checkbox"/> Keep airway open/watch breathing |
| <input type="checkbox"/> Turn child on side | <input type="checkbox"/> Other: _____ | |

Does student need to leave the classroom after seizure? yes no (If yes, please describe when student can arrive back to classroom)

Emergency Response: (Please check all that apply.)

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness.
- Student is injured, is pregnant or has diabetes.
- Student has a first-time seizure.
- Student has breathing difficulties.
- Student has a seizure while in the water.

Emergency Medications or Treatment:

Medication	Dosage, time and route	What to do after giving medication?	EMS Activated (Y/N)

Does student have a Vagus Nerve Stimulator (VNS)? yes no

If the answer is yes, list special precautions and considerations for use of the VNS magnet: (regarding school activities, field trips, extra curricular sports, etc.)

Type	Considerations/Precautions
School Activities	
Field Trips	
Sports	
Other	

Is the student on Ketogenic Diet? Yes No

Special Dietary Restrictions at school? Yes No

List: _____

Physician Signature: _____

Date: _____

School Nurse Signature: _____

Date: _____