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:

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

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 _____

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

INDIVIDUAL HEALTH CARE PLAN

Act 1565 (1999) amends Annotated Arkansas Code 6-18-1005 to require Individualized Health Care Plans for students with special health care needs in schools. **(This information is CONFIDENTIAL.)**

Student's Name _____ Date of Birth _____ Grade _____

School _____ Allergies _____

Student's Diagnosis _____

Brief History on medical condition _____

PROCEDURES AND INTERVENTIONS(TO BE COMPLETED BY PHYSICIAN OR CLINIC NURSE)

1. Does the student require assistance to attend school? _____ If YES, documentation in items 2-10 should support this requirement.

2. Health care treatments, medications, or procedures (i.e. blood sugars, caths) at school:
_____
_____

3. Health care treatments, medications, or procedures at home: _____
_____

4. Potential side-effects of medication(s) or treatment(s): _____

5. Transportation (bus, parent, etc.): _____

6. Suggested environmental modifications (seating in front of room, avoidance of specific allergens, etc.): _____
_____

7. List necessary equipment and supplies and person(s) responsible for providing these items:
_____
_____

8. Safety Measures: _____

9. Dietary requirements: (Certification of disability form must be completed for school to accommodate.): _____

10. Activity Limitations: _____

PLEASE ATTACH A COPY OF STUDENT'S MOST RECENT PHYSICAL EXAMINATION

Physician's Signature _____ **Date Signed** _____

Emergency Plan ( ) Attached ( ) Check if additional information is attached.