Gary W. Cumberland
Superintendent

Kelley Swartz
Director of Curriculum, Instruction & Assessment

Shawano School District

Louise Fischer
Business Manager

Lori Smits
Director of Pupil Services

SEIZURE ACTION PLAN

Student's Name_____ Date of Birth_____Grade_____

Parent/Guardian _____ Phone _____

Cell Phone/Alternative Phone_____

SEIZURE INFORMATION

Daily medications: _____

Type of seizures: _____

Seizure triggers/warning signs: _____

_____

Instructions specific to this student: _____

_____

EMERGENCY RESPONSE

CALL 911 IF:

- ❑ A convulsive (tonic-clonic) seizure lasts for more than 5 minutes
- ❑ Repeated seizures occur
- ❑ Difficulty in breathing
- ❑ Diabetic
- ❑ Seizure occurs in water
- ❑ Other _____

DOES THIS STUDENT HAVE EMERGENCY MEDICATION (DIASTAT) AT SCHOOL? YES❑ NO❑

PHYSICIAN DIRECTIONS _____

_____

BASIC FIRST AID

- Remain calm
- Send for help- school nurse or another adult
- Track time
- Clear immediate area to keep student safe, ask other students to step out
- Do not restrain
- Do not put anything in mouth
- Stay with student
- Maintain airway
- Turn student on side

Physician name _____ Phone _____

Physician signature _____ **Date** _____

Parent signature _____ **Date** _____