Veribest Independent School District
Health Services
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:___________

Treating Physician:____________________________ Phone: ______________

Significant medical history:____

SEIZURE INFORMATION:

Seizure Type	*Average length*	*Description*

Average frequency:______________

Seizure triggers or warning signs:______________________________

Student's reaction to seizure:__________________________________

BASIC FIRST AID: CARE & COMFORT: *(Please describe basic first aid procedures)*

Basic Seizure First Aid:
- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Turn child on side
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log
- ✓ Expect to see pale/bluish discoloration of skin or lips.

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing

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______________________

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

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

A Seizure is generally considered an Emergency and you should CALL 911 when:
- ✓ A seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties

TREATMENT PROTOCOL DURING SCHOOL HOURS:

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication

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Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use______________________________

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

Physician Signature:______________________________ **Date:**__________

Parent Signature:______________________________ **Date:**__________