



**YSLETA INDEPENDENT SCHOOL DISTRICT
STUDENT 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: _____ ID# _____
 Parent/Guardian: _____ Phone: _____ Cell: _____
 Other Emergency Numbers: _____
 Treating Physician: _____ Phone: _____ FAX: _____
 Significant Medical History/Diagnosis: _____

SEIZURE INFORMATION:

Seizure Type	Average Length	Description

Average Frequency: _____
 Seizure triggers or warning signs: _____
 Student's reaction to seizure: _____

BASIC FIRST AID/CARE & COMFORT:

Does student need to leave the classroom after a seizure? Yes No
 If **YES**, describe process for returning student to classroom

<p>Basic Seizure First Aid:</p> <ul style="list-style-type: none"> ✓ 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 <p><u>For tonic-clonic (grand mal) seizure:</u></p> <ul style="list-style-type: none"> ✓ Protect head ✓ Keep airway open/watch breathing ✓ Turn child on side
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Should 911 be called if seizure lasts less than 5 minutes? Yes No

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
- Notify doctor
- Administer emergency medications as indicated below
- Other _____

<p>A Seizure is considered an Emergency and 911 will be called when:</p> <ul style="list-style-type: none"> ✓ A convulsive (tonic-clonic) 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 seizure in water ✓ Student has breathing difficulties ✓ Slow recovery ✓ Signs in injury ✓ High fever or pain present after seizure

TREATMENT PROTOCOL DURING SCHOOL HOURS:

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

Emergency/ Rescue Medication: _____

Does student have a **Vagus Nerve Stimulator (VNS)**? Yes No

If **YES**, Describe magnet use _____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS:

Describe any special considerations or precautions (regarding school activities, sports, trips, etc.)

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____