Four County Career Center

Seizure Action Plan

Student Name_____ DOB _____

Lab Teacher_____ (Check one) AM _____ PM _____

Academic Teachers_____

Emergency Contacts

Name Relationship Home # Work # Cell #

1._____

2._____

3._____

Types of Seizures:_____

Age of Onset?_____ **Last time student had a seizure?**_____

How long do seizures last?_____

What does the seizure look like? _____

_____

Possible triggers that should be avoided: _____

_____

How long after the seizure before the student regains consciousness (postictal period)?_____

_____

Are medications needed to control the seizures? _____YES _____NO (list all medications below)

Medications Amount Taken How Often

1. _____

2. _____

3. _____

Side effects of
medication(s):_____

***Please turn form over-continues on back!!**

If Generalized (Grand Mal) Seizure Occurs:

- If falling, assist student to the floor, turn on their side.
- Loosen clothing at the neck, protect head from injury.
- Clear away furniture, objects and other students from the area.
- **Time the Seizure**
- Call the School Nurse
- Allow the seizure to run its course; DO NOT restrain or insert anything into the students' mouth. DO NOT try to stop purposeless behavior.
- During a Grand Mal seizure expect to see pale or bluish discoloration of the skin or lips and noisy breathing.
- Document seizure.

If smaller seizure occurs (E.G. lip smacking, behavior outburst, staring, twitching of mouth and hands)

- Assist student to comfortable sitting position.
- Time the seizure.
- Stay with the student, speak gently, and help the student get back on task following seizure.
- Reorient and assure student.
- Change into clean clothing as necessary.
- Allow student to sleep, as desired, after seizure.
- Allow student to eat, as desired, once fully alert and oriented.

****Parents will be notified of all seizures and actions taken.**

****911 will be called at the teacher and/ or school nurses' discretion.**

**** If you would like additional care given, please describe action here:**

_____

_____

_____

Physician Signature:_____ Date:_____

I want this plan implemented for my child, _____, at Four County Career Center. I hereby give my permission for the exchange of confidential information contained in the record of my child between the nurse and physician and my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

Parent/ Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____