

Seizure Action Plan

Date Effective:



**NORTH FOND DU LAC
SCHOOL DISTRICT**

305 McKinley Street
North Fond du Lac, WI 54937

**This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours

Student Information			
Student's Last Name		Student's First Name	
Parent/Guardian Information			
Parent/Guardian 1 Name:		Phone Number(s)	
		Home:	Cell: Work:
Parent/Guardian 2 Name:		Phone Number(s)	
		Home:	Cell: Work:
Other Emergency Contact			
Name/Relation		Phone Number(s)	
		Home:	Cell: Work:
Health Information			
Treating Physician		Phone #	
Significant Medical History			
<hr/> <hr/> <hr/>			
Seizure Information			
Seizure Type	Length	Frequency	Description
Seizure Triggers or Warning Signs:			
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Student's Response After a Seizure:			
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Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does the student need to leave the classroom after a seizure?
If YES, please describe process for returning student to classroom:

Emergency Response

A "seizure emergency" for this student is defined as:

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

- Contact School Nurse
- Call 911 for transport to
- Notify parent or emergency contact
- Administer emergency medications as indicated below
- Notify Doctor
- Other _____

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

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts more than 5 min.
- Student has repeated seizures w/out regaining consciousness
- Student is injured or diabetic
- Student has a first-time seizure
- Student has breathing difficulties
- Student has seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emergency Med <input checked="" type="checkbox"/>	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a Vagus Nerve Stimulator? If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Parent Complete:

I hereby give my permission for my child to receive the specialized procedure named above as prescribed by my child's physician. It is my understanding that the designated person(s) will be using the approved procedure. I agree to notify the school immediately of any changes in my child's health condition, physician or procedure.

Health Plan Reviewed:

_____ **Parent Signature** _____ **Date**

_____ **School Nurse Signature** _____ **Date**

For Physician use only:

Please circle one item:

- I have reviewed and approved the attached procedure as written.
- I have reviewed and approved the attached procedure with my modifications.
- I do not approve of the procedure. A substitute is attached.
*Authorization for this procedure is required annually.

_____ **Physician signature** _____ **Date**