School District of Iola-Scandinavia-Confidential

Health Services: Seizure Action Plan

Students Name:	Date of Birth:
Grade:	School Year:
Bus student: (Circle one) YES NO	Doctor Treating Seizures and Phone number:

Seizure Description:
Seizure Type: ____

Description of Seizure: ____
____

Possible triggers or warning of behavioral changes before a seizure: ____________________________________
____

How do illnesses affect your child's seizure control? ____

Frequency of seizures: _______ per _________. Last date of seizure was ______________________________

Average Length of Seizure Activity: ____________ Usual time of day of Seizure Activity: __________________

How long has your child had seizures? ____

How often does your child see the doctor regarding seizures? ____

Date of last appointment? ____

Daily Medication(s):

	Name	Route	Frequency	Given at school-(YES or NO)
1.				
2.				
3.				

<u>IF SMALLER SEIZURE OCCURS-Absent or Partial</u> (e.g., lip smacking, behavior outburst, staring, twitching of mouth or hands, walking around performing aimless activities, unaware of actions)

1. Assist student to comfortable, sitting position.
2. Time the seizure.
3. Stay with student, speak gently, and help student get back on task following seizure.
4. Contact parents-for further instruction

<u>IF GENERALIZED SEIZURE OCCURS-Convulsive</u>: Follow basic First Aid **Call 911**

1. If falling, assist student to floor, turn to side.
2. Loosen clothing at neck and waist; protect and cushion head from injury.
3. Clear away furniture and other objects from area.
4. Have another classroom adult direct students away from area.
5. TIME THE SEIZURE.
6. Allow seizure to run its course; DO NOT restrain or insert anything into student's mouth. Do not try to stop purposeless behavior.
7. During a general or grand mal seizure expect to see pale or bluish discoloration of the skin or lips. Expect to hear noisy breathing.
8. Administer emergency or rescue medications as prescribed from doctor-Stay with student until EMS arrives.
9. Contact parents!

*****Note: Most seizures are not medical emergencies. They end after a minute or two without harm*****

Emergency Medication(s):

Name: Route Frequency When to give medication

1.____

2.____

Post-seizure recovery measures:

____
____
____

Parent/Emergency Contact Information:

Mother	Father	Other
Name:	Name:	Name:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Work Phone:	Work Phone:	Work Phone:
E-mail address:	E-mail-address:	E-mail address:

Authorization is hereby granted to release this information to appropriate school personnel and classroom teacher to ensure safe management of your child's condition. If there are any questions or changes in this plan, please inform the School Nurse <u>and/or</u> office staff as soon as possible.

Parent/or legal guardian Signature: __________________________________Date: __________________________

School Nurse Signature: ____ Date: __________________________