



### Seizure Action Plan

(Physician signature/stamp required below)

School:	Grade:	Year:
Student's Last Name:	First Name:	<input type="checkbox"/> M <input type="checkbox"/> F Date of Birth:
 ____/____/____ (____) (____)		
Date	Parent/Guardian Signature	Home/Cell Phone Emergency Phone

### **Seizure Information:**

Seizure Type:	Length:	Frequency:	Description:
Seizure Triggers or Warning Signs:		Student's Response After Seizure:	

### **Basic First Aid:**

Please described basic first aid procedures:		<b><u>Basic Seizure First Aid:</u></b> <ul style="list-style-type: none"><li>▪ Stay calm &amp; track time</li><li>▪ Keep student safe</li><li>▪ Do not restrain</li><li>▪ Do not put anything in mouth</li><li>▪ Stay with student until fully conscious</li><li>▪ Record seizure in log</li></ul>
Does the student need to leave the classroom after a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, described process for returning student to classroom:		
<b><u>Emergency Response</u></b>		
Describe a "seizure emergency" for this student:	Seizure Emergency Protocol: (check all that apply) <ul style="list-style-type: none"><li><input type="checkbox"/> Contact school nurse at _____</li><li><input type="checkbox"/> Call 911 for transport to _____</li><li><input type="checkbox"/> Notify parent or emergency contact</li><li><input type="checkbox"/> Administer emergency medications as indicated below</li><li><input type="checkbox"/> Notify doctor</li><li><input type="checkbox"/> Other _____</li></ul>	<b><u>Seizure Emergency Defined As:</u></b> <ul style="list-style-type: none"><li>▪ Convulsive (tonic-clonic) seizure lasts longer than 5 minutes</li><li>▪ Student has repeated seizures without regaining consciousness</li><li>▪ Student is injured or has diabetes</li><li>▪ Student has a first-time seizure</li><li>▪ Student has breathing difficulties</li><li>▪ Student has a seizure in water</li></ul>

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

ER Med ✓	Medication	Dose and Time	Common Side Effects and/or Special Instructions

Does student have a Vagus Nerve Stimulator? ☐ Yes ☐ No If YES, describe magnet use:

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

(Licensed Prescriber's Stamp)	Licensed Prescriber's Printed Name: _____
	Licensed Prescriber's Signature: _____
	Date: ____/____/____
	Telephone Number: (____) _____

Rev 2/23

**\*\*Please note a new form is required every school year\*\***

**A Medication Administration Form Must Be Completed for Each Medication That is Listed on This Plan**

High School: 440.995.6805  
Middle School: 440.449.1413  
Center: 440.995.7405

**SCHOOL FAX NUMBERS**  
Gates Mills: 440.995.7505  
Lander: 440.995.7355  
Millridge: 440.995.7255

Excel TECC: 440.995.6755  
CEVEC: 440.646.1117  
Preschool: 440.995.6805