

North Brunswick Township School District

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. **School:** _____ **Hours:** _____

Student's Name: _____

Date of Birth: _____

Parent/Guardian: _____

Phone: _____ Cell: _____

Treating Physician: _____

Phone: _____

Significant medical history: _____

SEIZURE INFORMATION:

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

BASIC FIRST AID: CARE & COMFORT: (Please describe basic first aid procedures)

Does student need to leave the classroom after a seizure? YES ____ NO ____
If YES, describe process for returning student to classroom.

EMERGENCY RESPONSE:

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

- ☐ Contact school nurse, if nurse is not available, call 911
- ☐ Call 911 for transport
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Other _____

BASIC SEIZURE FIRST AID:

- Keep the child safe
- Explain to others
- Do not restrain.
- Do not put anything in mouth.
- Stay with child until fully conscious.
- For tonic-clonic
- Turn child on side.
- Protect head.

A SEIZURE IS GENERALLY CONSIDERED AN EMERGENCY WHEN:

- 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 breathing difficulties
- Student has a seizure in water

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

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

Does student require Emergency/Rescue Medication on the Bus? YES ____ NO ____

Does student require Emergency/ Rescue Medication for off-site trips? YES ____ NO ____

Does student have a Vagus Nerve Stimulator (VNS)? YES ____ NO ____

If YES, Describe magnet use. _____

BEFORE/ AFTER SCHOOL: School activities, sports, trips, transportation: **If the nurse is unavailable, call 911.**

I understand it is my responsibility to notify the school Nurse if my child is attending any school sponsored activities outside of the school day.

Parent Signature: _____ Date: _____

Print Physician Name: _____

Physician Signature: _____ Date: _____

Physician Stamp