Seizure Management and Treatment Plan

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

Student's Name	Date of Birth	
Parent/Guardian	Phone	Cell
Other Emergency Contact	Phone	Cell
Treating Physician	Phone	
Significant Medical History		

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: ❒ Missed Medicine ❒ Physical Stress ❒ Emotional Stress ❒ Illness with High Fever ❒ Flashing Lights ❒ Alcohol/Drugs ❒ Lack of Sleep ❒ Missed Meals ❒ Menstrual Cycle

Student's response after a 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:

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

Emergency Response

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

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

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

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

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use below:
Devices: ❒ VNS ❒ RNS ❒ DBS | Date Implanted:_____ Magnet Use Instructions:_____

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

Describe any special considerations or precautions:

_____

_____

Health Care Contacts:

Epilepsy Provider:_____ Phone:_____

Primary Care:_____ Phone:_____

Preferred Hospital:_____ Phone:_____

Pharmacy:_____ Phone:_____

Physician Signature_____ **Date**_____

Parent/Guardian Signature_____ **Date** _____