



FOUNTAIN HILLS UNIFIED SCHOOL DISTRICT #98

- McDowell Mtn.
- Middle School

- Four Peaks
- High School

**Place
Student
Photo
Here**

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.

Student's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____ Cell: _____

Treating Physician: _____ Phone: _____

Significant medical history: _____

SEIZURE INFORMATION:

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>

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 _____

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 (grand mal) seizure:
- ✓ Protect head
 - ✓ Keep airway open/watch

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
- Notify doctor
- Administer emergency medications as indicated below
- Other _____

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

Emergency/Rescue Medication _____

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO
If YES, Describe magnet use _____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*

Physician Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____