St Pius X Regional School
14710 Annapolis Road
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School Year: _____

SEIZURE ACTION PLAN

This Student is being treated for SEIZURE DISORDER. This ACTION PLAN guides their care in school & at ESP

Student's Full Name:_____ Date of Birth:_____
Parent/Guardian:_____ Home Phone: _____Cell:_____
Treating Physician:_____ Office Phone: _____Fax:_____
Significant medical history:_____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:_____
Student's usual reaction to seizure:_____

BASIC FIRST AID CARE & COMFORT: *(Specify preferred procedures):*

Does student need to leave the classroom after a seizure? NO YES*
**If YES, describe preferred 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 breathing
- ✓ Turn child on their side

EMERGENCY RESPONSE: *A "seizure emergency" for this student is defined as:*

Seizure Emergency Protocol: *(Check all that apply and explain/clarify below):*
- ☐ Contact School Nurse
- ☐ 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 *(always call 911)* when:
- ✓ A convulsive (tonic-clonic) seizure lasting longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured and/or has Diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure while 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(s): _____

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

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

_____

Physician Signature:_____ **Date:**_____

Parent Signature:_____ **Date:**_____