JEFFERSON TOWNSHIP PUBLIC SCHOOLS
SEIZURE ACTION PLAN

EPILEPSY FOUNDATION® Not another moment lost to seizures™

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:

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

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 side

EMERGENCY RESPONSE:

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

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

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_____

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:**_____

JEFFERSON TOWNSHIP PUBLIC SCHOOLS
Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

CONTACT INFORMATION

Student's Name:_____ School Year:_____ Date of Birth:_____
School:_____ Grade:_____ Classroom:_____
Parent/Guardian Name:_____ Tel. (H):_____ (W):_____ (C):_____
Other Emergency Contact:_____ Tel. (H):_____ (W):_____ (C):_____
Child's Neurologist:_____ Tel:_____ Location:_____
Child's Primary Care Dr.:_____ Tel:_____ Location:_____
Significant medical history or conditions:

SEIZURE INFORMATION

1. When was your child diagnosed with seizures or epilepsy?_____
2. Seizure type(s):

Seizure Type	*Length*	*Frequency*	*Description*

3. What might trigger a seizure in your child?_____
4. Are there any warnings and/or behavior changes before the seizure occurs? YES NO
   If YES, please explain:_____
5. When was your child's last seizure?_____
6. Has there been any recent change in your child's seizure patterns? YES NO
   If YES, please explain:_____
7. How does your child react after a seizure is over?_____
8. How do other illnesses affect your child's seizure control?_____

SEIZURE EMERGENCIES

9. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)_____
10. Has child ever been hospitalized for continuous seizures? YES NO
    If YES, please explain: _____

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SEIZURE MEDICATION AND TREATMENT INFORMATION

***Doctor's orders and parent/guardian written consent required for administration of medication at school.**

11. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and time of day taken	Possible side effects

12. What emergency/rescue medications needed medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to do after administration:

* *After 2nd or 3rd seizure, for cluster of seizure, etc.* ** *Orally, under tongue, rectally, etc.*

13. What medication(s) will your child need to take during school hours?_____
14. Should any of these medications be administered in a special way? YES NO
    If YES, please explain:_____
15. Should any particular reaction be watched for? YES NO
    If YES, please explain:_____
16. What should be done when your child misses a dose?_____
17. Should the school have backup medication available to give your child for missed dose? YES NO
18. Does your child have a Vagus Nerve Stimulator? YES NO
    If YES, please describe instructions for appropriate magnet use:_____
    _____

SPECIAL CONSIDERATIONS & PRECAUTIONS

22. Check all that apply and describe any considerations or precautions that should be taken

- ❑ General health_____
- ❑ Physical functioning_____
- ❑ Learning:_____
- ❑ Behavior:_____
- ❑ Mood/coping:_____
- ❑ Physical education (gym)/sports:_____
- ❑ Recess:_____
- ❑ Field trips:_____
- ❑ Bus transportation:_____

Other:_____

GENERAL COMMUNICATION ISSUES

23. What is the best way for us to communicate with you about your child's seizure(s)?_____
24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent/Guardian Signature:_____ Date:_____ Dates Updated:_____, _____