FORSYTH COUNTY SCHOOLS
Quality Learning and Superior Performance for All

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:

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)**

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

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:

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
- ✓ Person is pregnant

Seizure Emergency Protocol: *(Check all that apply and clarify below)*
- ☐ Contact school nurse at _____
- ☐ 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**. If Administered, 911 will be called.**

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 Statement:
I am requesting the administration of Diastat/Intranasal Versed as ordered in the FCS Seizure Action Plan for the treatment of prolonged seizures in the school setting. I understand and agree that Diastat/Intranasal Versed will be administered by a trained lay person and that monitoring equipment such as blood pressure cuffs, oximetry, etc. will not be available at the school during administration.

_____ _____ _____
Physician Name (PRINT) Physician Signature Date

Parent Signature:_____ **Date:**_____

Reviewed by: _____ **Date:**_____

*Refer to 504 coordinator if appropriate

Updated 3/19