



SEIZURE ACTION PLAN

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

Student _____ Birthday _____ Grade _____

Mother/Guardian _____ Home _____ Cell _____ Work _____

Father/Guardian _____ Home _____ Cell _____ Work _____

Treating Physician _____ Phone _____

Seizure Information – This section to be completed by the Parent.

Seizure Type _____ Usual Length _____

Seizure Description _____

Seizure triggers or warning signs _____

Student's response after a seizure _____

Parent/Guardian Signature _____ Date _____

Basic Seizure First Aid:

- Time Seizure
- Ease student to the floor
- Position student on their side
- Keep airway open/watch breathing
- Clear area of any objects that could injure student
- Place something soft under student's head
- Do not put anything in student's mouth or restrain student
- Call nurse

This section to be completed by the Physician

Medication _____ Dosage _____ Time to be given _____

Date to begin _____ Date to end _____

Physician Signature _____ Phone _____ Date _____