CATOOSA COUNTY PUBLIC SCHOOLS
SEIZURE ACTION PLAN

School:_____ **School Year:**_____ **Date:**_____

Student Name:_____ **DOB:**_____
Teacher: _____ **Grade Level:**_____
Parent/Guardian: _____
#1 Phone _____ **#2 Phone** _____
Emergency Contact: _____ **Phone #:** _____

I understand that it is my responsibility as the parent/guardian of _____ to notify the school nurse/designee of any changes in my child's health condition and/or medication/treatment regimen. I authorize my child's physician and his/her staff to release information regarding my child's health condition. I understand that this health information will ONLY be shared with pertinent school staff.

_____ _____
Parent/Guardian Signature **Date**

SEIZURE INFORMATION:

Significant Medical History:_____

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:_____
Student's response after a seizure:_____

EMERGENCY RESPONSE:

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

_____

Seizure Emergency Protocol:
(*Check all that apply and clarify below*)
☐Contact School Nurse
☐Call 911
☐Notify parent or emergency contact
☐Notify doctor
☐Administer emergency medications as indicated below
☐Other _____

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**

A Seizure is generally considered and Emergency when:
- ✓ **A convulsive (tonic-clonic) seizure last 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**

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS:

(regarding school activities, sports, trips, etc.)

_____

_____

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

TREATMENT PROTOCOL DURING SCHOOL HOURS (Include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects and Special Instructions

Emergency/Rescue Medication:_____

Physician Signature: _____
Date:_____

Physician Address/Phone/Fax

Form Adapted from the Epilepsy Foundation
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