Ocean Springs School District
Seizure History and Action Plan

Name:_____ DOB:_____ Grade: ____

Teacher: _____

Diagnosis:_____ Age of diagnosis: _____
Allergies: _____

Other Medical Conditions: _____

CURRENT MEDICATION PROFILE:

Drug Name: _____ Amount: _____ How Often: _____

Drug Name: _____ Amount: _____ How Often: _____

Drug Name: _____ Amount: _____ How Often: _____

Medication side effects: _____

If student requires medication at school please complete a Medication Permission Request Form

SEIZURE HISTORY:

Date of last seizure: _____Frequency of seizures: _____

How often does student see the doctor regarding seizures? _____

When was last appointment? _____

Activity Restrictions: _____

Check any special considerations related to seizure condition while at school and describe them:

1. Educational Concerns: _____
2. Behavioral Concerns: _____
3. Emotional Concerns: _____
4. Physical Education Precautions: _____
5. Recess Precautions: _____
6. Special Considerations for Field Trips: _____

7. Special Transportation to and from School: _____
8. Other: _____

DESCRIPTIONS / SYMPTOMS:

Is there a difference between past and current seizure patterns? If so, how have they changed:_____

How do other illnesses affect seizure control?: _____

Warnings, triggers or behavior seen before seizure: _____

Describe typical seizure: _____

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Actions to take during a seizure:_____

How long does a "typical" seizure last: _____

Student's "typical" reaction after the seizure episode: _____

The nurse will Call 911 immediately if :

1. Multiple seizures compromise airway
2. Seizure lasting over _____ mins
3. If student is injured/ stops breathing (**Initiate CPR**)

Physician name and phone number:_____

SPECIAL INSTRUCTIONS: _____

_____
Parent Signature

_____
Date