Bartow County School System Clinic Form for 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's Name: _____ Date of Birth: _____
Parent/Guardian: _____ Phone: _____ Cell: _____
Treating Physician: _____ Phone: _____
Significant Medical History: _____

SEIZURE INFORMATION

Seizure Type	*Length*	*Frequency*	*Description*
1._____	_____	_____	_____
2. ._____	_____	_____	_____
3. ._____	_____	_____	_____

Seizure Triggers or Warning Signs: _____

Student's Reaction to Seizure: _____

If the student has a seizure at school, does he/she need to leave the classroom? YES NO
If YES, describe process for returning to the classroom:_____

BASIC FIRST AID: CARE & COMFORT:

- Stay calm and track time of seizure activity
- Keep child safe
- Do not restrain
- Do not put anything in the mouth
- Stay with the child until fully conscious
- Record seizure in log (if parents request/provide)

FOR TONIC CLONIC/GRAND MAL SEIZURE

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A seizure emergency defined for this child is:_____

Seizure Emergency Protocol (check all that apply)

____ Administer emergency medicine ____ Call 911 ____ Notify parent/Guardian

Emergency and/or Daily Seizure Medication(s) to be administered at school:

Medication	Dosage	Route	Time	Special Instructions
Medication	Dosage	Route	Time	Special Instructions

_____ _____ _____ _____
Physician's Signature ***Date*** ***Parent/Guardian Signature*** ***Date***