

Student Photo

Effective Date \_\_\_\_\_

Columbus ISD

# Seizure Action Plan

(please print)

Student has permission to transport medication listed below to and from school?

YES  NO

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
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Parent/Guardian	Phone	Cell
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Other Emergency contact	Phone	Cell
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Treating Physician	Phone
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Significant Medical History:

### Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:	Student's response after a seizure:
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### Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure?  Yes  No  
If Yes, describe process for returning student to classroom.

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

### Emergency Response

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

- Seizure Emergency Protocol**  
Check all that apply and clarify below)
- Contact campus nurse at \_\_\_\_\_
  - Call 911 for transport to \_\_\_\_\_
  - Notify parent or emergency contact
  - Administer emergency medications as indicated below
  - Notify doctor
  - Other \_\_\_\_\_

- A seizure is generally considered an Emergency when:**
- Convulsive (tonic-clonic) seizures lasts longer than 5 minutes
  - Student has repeated seizures without regaining consciousness
  - Student is injured or has diabetes
  - Student has a first time seizure
  - Student has breathing difficulties
  - Student has a seizure in water

### Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med <input checked="" type="checkbox"/>	Medication	Dosage & Time of Day Given	Common Side Effects/Special Instructions

Does student have a **Vagus Nerve Stimulator**?  Yes  No If YES, describe magnet use:

### Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature	Date
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Parent/Guardian Signature	Date
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