Seizure Action Plan For School

(To Be Completed By Health Care Provider and Parent)

Student Name: _____ Date of Birth: _____

Trigger(s): _____

Daily Medication(s): _____

1. If you see this:	**1. Do this:**
Blank staring with an inability to focus or speak	❑ Note the time the behavior begins. ❑ Call the office for nurse or trained person. ❑ If lasts longer than _____ minutes, trained person to give_____. ❑ Report to parent. ❑ Allow rest if needed. ❑ Other: _____

2. If you see this:	**2. Do this:**
Jerking of localized area of body/muscle tension of localized area of body.	❑ Note the time the behavior begins. ❑ Clear all objects from surrounding area. ❑ If appears unsteady on chair/feet, place onto lying position on left side on floor. ❑ Loosen any tight clothing from neck. ❑ Call the office for nurse or trained person. ❑ If lasts longer than _____ minutes, trained person to give_____. ❑ Report to parent. ❑ Allow rest if needed. ❑ Other: _____

3. If you see this:	**3. Do this:**
Jerking of entire body/muscle tension of entire body.	❑ Note the time the behavior begins. ❑ Clear all objects from surrounding area. ❑ Place onto lying position on left side on floor. ❑ Loosen any tight clothing from neck. ❑ Call the office for nurse or trained person. ❑ If lasts longer than _____ minutes, trained person to give_____. ❑ Report to parent. ❑ Allow rest if needed. ❑ Other: _____

HealthCare Provider: _____ Phone#_____
(Please Print) Fax#_____
Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date:_____
Home Phone#_____ Work Phone#_____ Cell Phone#_____

It is the responsibility of the parent to notify the school and provide an updated plan upon any change.