Mecklenburg County Health Department
School Health Program

SEIZURE EMERGENCY ACTION PLAN Name: _____

School: _____Year: _____ Grade: _____ Date of Birth: _____ Allergies:_____

Homeroom Teacher: _____ Room: _____ Student ID #:_____

Parent/Guardian: _____ Ph. (H): _____

Address: _____ Ph. (W): _____

Parent/Guardian: _____ Ph. (H): _____

Address: _____ Ph. (W): _____

Emergency Phone Contact #1: _____ _____ _____

Name Relationship Phone

Emergency Phone Contact #2: _____ _____ _____

Name Relationship Phone

Physician treating student for seizure disorder : _____ Phone: _____

Other Physician: _____ Phone: _____

Preferred Hospital: _____

EMERGENCY PLAN

(Fill in blanks, cross out and initial any steps not needed for this student.)

Emergency action is necessary when the student has the following symptoms: _____

_____

Steps to take during a seizure:

1. Stay with student during and after seizure. Note duration of seizure and type of body movement during seizure episode.

2. Assist to lying position if loss of consciousness occurs. Remove glasses if wearing, loosen clothing around neck.

3. Turn on side as soon as possible.

4. Clear area around child to prevent injury; remove other students from area if possible.

5. **DO NOT RESTRAIN MOVEMENT OR PLACE ANYTHING IN MOUTH.**

6. Monitor breathing and begin artificial respiration if breathing does not resume spontaneously.

7. Call 911 if seizure lasts longer than 5 minutes, the student has one seizure after another without waking or there are signs of significant injury or physical/respiratory distress. If 911 is called, transport to _____Hospital.

8. When seizure is over, allow child to rest and always notify parent/guardian.

9. Notify school nurse.

Other instructions for this student: _____

_____

Daily Seizure Management Plan:

1. What type of seizures does your child have and how often do they occur? _____

   _____

   Date of last seizure: _____

2. Describe your child's symptoms during and after a seizure episode. _____

   _____

3. Does your child have an aura or warning of a seizure coming? Yes __ No __

   Is he/she able to notify anyone that a seizure is coming? Yes __ No __

4. Name medications taken routinely. How often and how much?

   At home: _____

   At school: _____

   Does your child experience any side effects to these medications? Please list:

   _____

   Are there any sports/activities in which your child CANNOT participate?

   _____

*** PLEASE NOTE: If medications are to be taken at school, a Medication Authorization form must be completed by the parent and physician and kept at the school.**

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

This information will be shared with appropriate school staff unless you state otherwise.