



# Seizure Action Plan

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Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Treating Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Seizure Type	Length	Frequency	Description

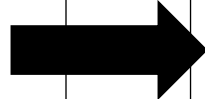
Seizure triggers & warning signs: \_\_\_\_\_

Student response after seizure: \_\_\_\_\_

## Emergency Response

### A Seizure Emergency for this student is defined as:

- Seizure lasts longer than \_\_\_\_\_ minutes
- Student has \_\_\_\_\_ repeated seizures
- Other \_\_\_\_\_



### Seizure Emergency Protocol

(Check all that apply and clarify below)

- Call 911 for transport
- Notify parent or emergency contact
- Administer emergency medications as indicated below
- Notify doctor
- Contact school nurse
- Other \_\_\_\_\_

### Basic 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

### A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure 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

Does student need to leave the classroom after a seizure? YES NO

If YES, describe process for returning student to classroom: \_\_\_\_\_

Describe Special Considerations and Precautions

(regarding school activities, sports, trips) \_\_\_\_\_

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

Emergency Contact 1:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Relationship

Emergency Contact 2:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Relationship

Emergency Contact 3:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Relationship

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

Medication	Dosage	Time Given	Common side Effects/Special Instructions

Please contact the office at your child's school regarding the Medication Policies of the Ada City School District. If your child must take prescription or over-the-counter medication during the school day, he or she must have a current Medication Consent Form on file signed by a physician and a parent or guardian.

## Seizure IHP

**Assessment Data:** (check or circle if applicable)

**Signs/ Symptoms:**

**Triggers**

<input type="checkbox"/> Aimless Wandering <input type="checkbox"/> Fluttering eyelids <input type="checkbox"/> Falling down <input type="checkbox"/> Blank stare <input type="checkbox"/> Confusion <input type="checkbox"/> Muscle stiffness <input type="checkbox"/> Rhythmic convulsions <input type="checkbox"/> Purposeless activity <input type="checkbox"/> Fluttering eyelids <input type="checkbox"/> Repetitive acts/movements <input type="checkbox"/> Loss of Control: Bowel    Bladder    Saliva (drooling) <input type="checkbox"/> Twitching of body part: which part _____ <input type="checkbox"/> Other (Describe) _____	<input type="checkbox"/> Bright lights/ strobe lights <input type="checkbox"/> Temperature changes <input type="checkbox"/> Fatigue <input type="checkbox"/> Stress <input type="checkbox"/> Loud noises <input type="checkbox"/> Hunger <input type="checkbox"/> Fever <input type="checkbox"/> Other: _____
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Frequency of seizure episodes: \_\_\_\_\_ # of hospitalizations in last 12 months \_\_\_\_\_

Has positive support system: Y/N Describe: \_\_\_\_\_

<b>Nursing diagnosis:</b> 1. Potential for physical and emotional trauma r/t seizures 2. Potential for less than optimal school achievement r/t seizures 3. Deficient knowledge r/t seizure disorder and triggers 4. Risk for delayed development r/t seizures 5. Situational low self-esteem r/t seizure disorder 6. Other: _____	<b>Goals:</b> 1. Increase knowledge about seizures and the student's specific triggers 2. Participate in regular school/class activities, including physical education class, with modifications made as necessary. 3. Seeks assistance when needed 4. Increased school attendance 5. Seizures will be controlled for optimum school participation 6. Reduce physical and emotional trauma r/t seizures 7. Other: _____
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**Interventions:** (check if applicable)

- \_\_\_\_\_ Protect student from harm during seizure; place something soft under student's head
- \_\_\_\_\_ Do not attempt to put anything in student's mouth or restrain student
- \_\_\_\_\_ Monitor and record seizure activity and length
- \_\_\_\_\_ Call 911 and parent if seizure lasts more than \_\_\_\_\_ minutes. If seizure last >5 minutes, 911 will be called.

**Health Education:** U= understands N= needs more information

	Date	Date	Date	Date
Signs/ Symptoms				
Restricted activities				
Adequate sleep				
Triggers				
Out-of-school resources				
Medic alert bracelet				

**Student Outcomes**

1. Student will be physically and emotionally free from trauma of seizures
2. Student will experience minimal seizure activity.
3. Student will demonstrate/describe activities in Health Education.
4. Student will obtain adequate sleep.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Nurse Signature: \_\_\_\_\_

Date: \_\_\_\_\_