

## Seizure Action Plan For Southgate School

Students Name: \_\_\_\_\_ D.O.B \_\_\_\_\_

Student's  
Picture

School \_\_\_\_\_ Teacher \_\_\_\_\_

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

### \*Emergency Contacts

|    | Name  | Relationship | Home# | Work# | Cell# |
|----|-------|--------------|-------|-------|-------|
| 1. | _____ | _____        | _____ | _____ | _____ |
| 2. | _____ | _____        | _____ | _____ | _____ |
| 3. | _____ | _____        | _____ | _____ | _____ |

Type of Seizure: \_\_\_\_\_

What does the seizure look like and how long does it usually last? \_\_\_\_\_

\_\_\_\_\_

Possible triggers that should be avoided? \_\_\_\_\_

\_\_\_\_\_

Does student need any special activity adaptation/protective equipment (e.g. Helmet) at school?: \_\_\_\_\_ No \_\_\_\_\_ Yes(explain) \_\_\_\_\_

\_\_\_\_\_

Is student allowed to participate in physical education and other activities?

\_\_\_\_\_ Yes \_\_\_\_\_ No (explain) \_\_\_\_\_

Are medication needed to control the seizures \_\_\_\_\_ No \_\_\_\_\_ Yes (List the medication)

| Medication | Amount taken | How often and for what signs |
|------------|--------------|------------------------------|
|------------|--------------|------------------------------|

1. \_\_\_\_\_

2. \_\_\_\_\_

List the medication needed at school (name dosage/route, and frequency)

\_\_\_\_\_

Possible side effects that must be reported to parent

\_\_\_\_\_

**IF GENERALIZED SEIZURE OCCURS:**

1. If falling, assist student to the floor, turn to the side.
2. Loosen clothing at neck and waist; protect head from injury.
3. Clear away furniture and other objects from area.
4. Have another classroom adult direct student away from area.
5. **TIME THE SEIZURE.**
6. Allow seizure to run its course; **DO NOT** restrain or insert anything into student's mouth. **DO NOT** try to stop purposeless behavior.
7. During a general or grand mal seizure expect to see pale or bluish discoloration of skin or lips. Expect to hear noisy breathing.

**IF A SMALLER SEIZURE OCCURS** (e.g., lip smacking, behavior outbursts, staring, twitching of mouth or hands)

1. Assist student to comfortable, sitting position.
2. **TIME THE SEIZURE.**
3. Stay with the student, speak gently, and help student get back on task following seizure.

**IT IS AN EXTREME EMERGENCY IF STUDENT EXHIBITS:**

1. Absence of breathing or pulse
2. Seizure of 10 minutes or greater duration.
3. Two or more consecutive (without a period of consciousness between) seizures with total 10 minute or greater.
4. Continued unusually pale or bluish skin or lips or noisy breathing after the seizure has stopped.

**THE INTERVENTION IF THE STUDENT EXHIBITS THE ABOVE SYMPTOMS:**

1. Call 911
2. START CPR for absent breathing or pulse.

**WHEN THE SEIZURE IS COMPLETED:**

1. Reorient and assure student
  - a) Assist change into clean clothing if necessary.
  - b) Allow student to sleep, as desired, after seizure.
  - a) Allow student to eat, as desired, once fully alert and oriented.
2. A student recovering from a generalized seizure may manifest abnormal behavior such as incoherent speech, extreme restlessness, and confusion. This may last from five minutes to hours.
3. Inform parent immediately of seizure via telephone conversation if:
  - a) Seizure is different from usual frequency or has not occurred at school in the past.
  - b) Seizure meets criteria for 911 emergency call
  - c) Student has not returned to "normal self" after 30-60 minutes
4. Record seizure on Seizure Activity Log.

**If you and your physician want additional care/orders given, describe action here:**

**If symptoms are:**

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**Give:**

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**(Medication/dose/route)**

**Possible side effects**

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**Additional Orders:**

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**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print Name** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent Email Address:** \_\_\_\_\_

**School Nurse:** \_\_\_\_\_ **Date** \_\_\_\_\_

**\*PLEASE INFORM YOUR CONTACTS THAT THEY ARE THE EMERGENCY CONTACT AND WHAT TO DO IF THERE IS AN EMERGENCY.**