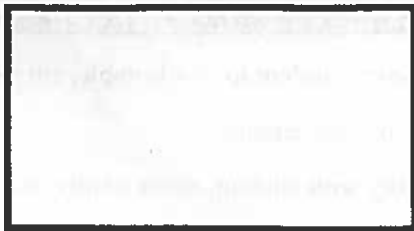


# SEIZURE ACTION PLAN FOR SCHOOL



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

School: Benton Central Jr/Sr High School

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

## EMERGENCY CONTACTS:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

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

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

3. \_\_\_\_\_

Type of seizure : \_\_\_\_\_

What does the seizure look like: \_\_\_\_\_

How long does it usually last: \_\_\_\_\_

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

Does student need any special activity adaptations/protective equipment (e.g., helmet) at school?

No: \_\_\_\_\_ Yes: \_\_\_\_\_ Explain: \_\_\_\_\_

Is student allowed to participate in physical education and other activities? No: \_\_\_\_\_ Yes: \_\_\_\_\_

Explain: \_\_\_\_\_

ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Please list the medications needed:

<u>MEDICATION:</u>	<u>DOSE/AMOUNT TAKEN:</u>	<u>TIME/S TAKEN</u>	<u>FOR WHAT SYMPTOMS:</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

List medication needed at school (name, dosage, route, and frequency): \_\_\_\_\_

Possible side effects that must be reported to parent or physician: \_\_\_\_\_

## IF GENERALIZED SEIZURE OCCURS:

1. If falling, assist student to floor, turn to 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 students 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 the skin or lips. Expect to hear noisy breathing.