CHULA VISTA ELEMENTARY SCHOOL DISTRICT

84 East "J" Street • Chula Vista, CA 91910 • (619) 425-9600

SEIZURE ACTION PLAN

School Year _____

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name:_____ Date of Birth:_____

Parent/Guardian:_____ Phone:_____Cell:_____

Treating Physician:_____ Phone: _____

Significant medical history:_____

SEIZURE INFORMATION: Date of last known seizure during the day _____

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:_____

Student's reaction to seizure:_____

Medication regularly taken at home (include dosage and times given): _____

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

If YES, describe process for returning student to classroom. _____

Does student have a Vagus Nerve Stimulator (VNS)? **NO** **YES**

If YES, Describe magnet use_____

BASIC FIRST AID: CARE & COMFORT INCLUDES

- 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 (grand mal) seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side
- Call 911 if licensed nurse is not on site

EMERGENCY RESPONSE: A "seizure emergency" for this student is defined as: _____

- ○ Notify school nurse
- ○ Notify parent/emergency contact
- ○ Notify doctor
- ○ Other_____

A Seizure is *generally* considered an emergency when:

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

Medication to be taken at school:

Medication	Dosage and Time	Indications and Special Instructions

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding school activities, sports, trips, etc.)*_____

_____

_____

I will notify the school immediately and submit a new form if there are changes in medication, dosage, time of administration. I authorize school health professional to communicate with the prescribing physician when the school or physician want more information about seizure management at school.

Physician Signature:_____License #_____Date:_____

Parent Signature:_____Date:_____

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