

WILMINGTON AREA SCHOOL DISTRICT SEIZURE ACTION PLAN

Place
Child's
Photo
Here

Student Name: _____ **DOB:** _____ **Grade:** _____

Parent/Guardian: _____ Phone: _____ Cell: _____

Parent/Guardian: _____ Phone: _____ Cell: _____

Other contact: _____ Phone: _____ Cell: _____

Primary provider: _____ Phone: _____

Specialist: _____ Phone: _____

Hospital Preference: _____

Significant medical history: _____

Daily and Emergency Medicines:

Daily Medicines	Dose & Time of Day Given	Common Side Effects & Special Instructions

Emergency Medicine	How to give & How much	When to give medicine	Common Side Effects / Special Instructions

Do I have a **Vagus Nerve Stimulator (VNS)**? YES NO
If YES, Describe magnet use _____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: (regarding triggers, activities, sports, trips, etc.)

SEIZURE INFORMATION:

What do I need to avoid to reduce my seizures? _____

What my seizure looks like?	What do I need for this?	What I need after this?
	<p>Basic Seizure First Aid:</p> <ul style="list-style-type: none"> ✓ Stay calm & track time ✓ Keep me/my child safe ✓ Do not restrain me ✓ Do not put anything in mouth ✓ Stay with my/my child until fully awake ✓ Record seizure in log <p>For tonic-clonic (grand mal) seizure:</p> <ul style="list-style-type: none"> ✓ Protect head ✓ Keep airway open/watch breathing ✓ Turn me/my child on side 	
What is a "seizure emergency" for me?	<p>A seizure is generally considered an emergency when:</p> <ul style="list-style-type: none"> ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes ✓ I/my child has repeated seizures without regaining consciousness ✓ I/my child has a first time seizure ✓ I/my child is injured or has diabetes ✓ I/my child has breathing difficulties ✓ I/my child has a seizure in water 	<ul style="list-style-type: none"> <input type="checkbox"/> Call 911 for transport to closest Hospital <input type="checkbox"/> Notify parent or this emergency contact – Name: _____ Number: _____ <input type="checkbox"/> Notify doctor <input type="checkbox"/> Administer emergency medicines as indicated above <input type="checkbox"/> Other _____

Physician Signature: _____ **Clinic:** _____ **Date:** _____

(Required)

Parent Signature: _____ **Date:** _____

(Required)