

**CATOOSA COUNTY PUBLIC SCHOOLS
SEIZURE ACTION PLAN**

School: _____ School Year: _____ Date: _____

Student Name: _____ DOB: _____

Teacher: _____ Grade Level: _____

Parent/Guardian: _____

#1 Phone _____ #2 Phone _____

Emergency Contact: _____ Phone #: _____

I understand that it is my responsibility as the parent/guardian of _____ to notify the school nurse/designee of any changes in my child's health condition and/or medication/treatment regimen. I authorize my child's physician and his/her staff to release information regarding my child's health condition. I understand that this health information will ONLY be shared with pertinent school staff.

Parent/Guardian Signature _____ Date _____

SEIZURE INFORMATION:

Significant Medical History: _____

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Student's response after a seizure: _____

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol:

(Check all that apply and clarify below)

- Contact School Nurse
- Call 911
- Notify parent or emergency contact
- Notify doctor
- Administer emergency medications as indicated below
- Other _____

Basic Seizure 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 (grand mal) seizure:

- ✓ Protect head
- ✓ Keep Airway open/watch breathing
- ✓ Turn child on side

A Seizure is generally considered and Emergency when:

- ✓ A convulsive (tonic-clonic) seizure last 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

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS:

(regarding school activities, sports, trips, etc.)

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

Describe magnet use: _____

TREATMENT PROTOCOL DURING SCHOOL HOURS (Include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects and Special Instructions

Emergency/Rescue Medication: _____

Physician Signature: _____

Date: _____

Physician Address/Phone/Fax