SEIZURE Emergency Action Plan

Keller ISD Health Services Department

Name:_____ **DOB:**_____ **Teacher/Grade:**_____

Emergency Contact #1:_____ **Preferred Contact #:**_____

Emergency Contact #2:_____ **Preferred Contact #:**_____

Physician Treating Seizures:_____ **Preferred Contact #:**_____

Preferred Hospital:_____

Diagnosis/Condition: **SEIZURE DISORDER** Type of Seizures: _____

Date of Last Seizure:_____

PLEASE CHECK THE STUDENT'S SIGNS AND SYMPTOMS:

- ☐ Loss of consciousness
- ☐ Falling down
- ☐ Muscle stiffness
- ☐ Confusion
- ☐ Repetitive movement
- ☐ Aimless wandering
- ☐ Fluttering eyelids
- ☐ Blank stare
- ☐ Purposeless activity
- ☐ Twitching/Jerking of body parts
- ☐ Loss of Control (bladder, bowels, drooling)
- ☐ Rhythmic convulsions
- ☐ Other:_____

PLEASE CHECK ANY TRIGGERS FOR STUDENT'S SEIZURE:

- ☐ Bright light/strobe
- ☐ Temperature (hot/cold)
- ☐ Stress
- ☐ Loud Noises
- ☐ Fever
- ☐ Fatigue
- ☐ Hunger
- ☐ Other:

ACTION IF STUDENT HAS A SEIZURE AT SCHOOL:

☐ **Rest**

☐ **Call parent**

☐ **Call 911 when**_____

911 will always be called if seizure lasts longer than 5 minute AND/OR

- If student has repeated seizures
- If student has trouble breathing
- If student cannot be aroused after seizure
- If student is pregnant, diabetic, or has no known seizure history

☐ **Administer following emergency medication(s):** (additional form(s) required for medications)

Emergency Medication Name	Medication/Magnet Location	Dosage	Route	Trained Staff/ Extension	Buddy Nurse/ Extension
Vagal Nerve Stimulator **Special Procedure Form Required**		N/A	N/A		

Student's Name: _____ **DOB**: _____

DIAGNOSIS/CONDITION: SEIZURES **TYPE OF SEIZURE:** _____

Additional Information:

Acknowledged and Received By:

Parent Signature: _____ **Date:** _____

Registered Nurse Signature: _____ **Date:** _____

Licensed Vocational Nurse Signature: _____ **Date:** _____

☐ Seizure EAP electronically sent via Laserfiche to all staff directly involved with student services. Date: _____