



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:

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

PLEASE CHECK ANY TRIGGERS FOR STUDENT'S SEIZURE:

- | | | | |
|---|--------------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Bright light/strobe | <input type="checkbox"/> Stress | <input type="checkbox"/> Fever | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Temperature (hot/cold) | <input type="checkbox"/> Loud Noises | <input type="checkbox"/> Fatigue | |
| | | <input type="checkbox"/> Hunger | |

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)

Medication Name	Route	Dosage	Frequency

Vagal Nerve Stimulator (Special Procedure Form is required)

Student's Name: _____ DOB: _____

DIAGNOSIS/CONDITION: SEIZURES TYPE OF SEIZURE: _____

Additional Information:

EMERGENCY INTERVENTION: (ADDITIONAL FORMS REQUIRED)

<u>Emergency Medication</u>	<u>Diastat</u>	<u>Vagal Nerve Stimulation</u>
Medication Name/ Location:	Diastat Location:	Magnet Location:
Trained staff/location:	Trained staff/location:	Trained staff/location:
Trained staff/location:	Trained staff/location:	Trained staff/location:
Buddy Nurse/location:	Buddy Nurse/location:	Buddy Nurse/location:
Other:	Other:	Other:

Acknowledged and Received By:

Parent Signature: _____ Date: _____

Teacher Signature: _____ Date: _____

Teacher Signature: _____ Date: _____

Registered Nurse Signature: _____ Date: _____

Licensed Vocational Nurse Signature: _____ Date: _____