Desoto Independent School District
Health Services 2019-2020
Seizure Action Plan

Student Name:____ **DOB:** ________________ **Grade:** ________

Weight:_________lbs Significant Medical History: ____

Does the student have a **Vagus Nerve Stimulator?** ________ If YES, describe magnet: _______________________________

Seizure Type	Length	Frequency	Description

Basic First Aid: Care & Comfort Response
Describe first aid procedures: ____

____

Does the student need to leave the classroom following a seizure? (YES/NO)
If YES, describe the process for returning the student to the classroom:

____

____

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

Emergency Protocol: (Check all that apply and clarify as needed)

- Contact school nurse at _______________
- Call 911 for transport to _______________
- Notify parent or emergency contact
- Administer emergency medications as indicated below
- Notify healthcare provider listed
- Other________________________________

Basic Seizure First Aid:
- Stay calm & track time
- Keep student safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:
- Protect head
- Monitor airway/breathing
- Turn student on side

Seizures generally considered emergent:
- Convulsive (tonic-clonic) seizure lasting longer than 5 minutes
- Repeated seizures without regaining consciousness
- Student is injured or has diabetes
- New onset seizure
- Student has breathing difficulties
- Seizure occurs in water

Emer. Med?	Medication	Dosage & Time Given	Side Effects & Comments

Special Considerations or Precautions: (regarding school activities, sports, trips, etc.)

Desoto Independent School District
Health Services 2019-2020
Seizure Action Plan

Physician/Healthcare Provider Signature:____ Date: _____________

Physician Printed Name and Telephone Number: ____

Dear Parent/Legal Guardian:

The health and safety of your child is very important to us. On your child's health information sheet you indicated they have a seizure disorder. Please take the time to fill out the bottom of this form, and have your child's physician or other healthcare provider fill out the Seizure Action Plan on the back of this form.

Please return these forms and any necessary daily and emergency medications (i.e. Keppra, Diastat, etc.) to the nurse's office as soon as possible.

Your child's teachers will be updated on their condition and will allow them to come to the nurse's office for evaluation and/or treatment when needed.

If you have any questions or concerns, please feel free to contact your campus nurse.

Student's Name:__________________________________ **Grade:** ____ **ID #:** ____________________________

I hereby give permission to the school nurse or school personnel designated by the principal to administer medication to my child as prescribed in the Seizure Action Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition to this, I understand that this information will be shared with school staff as deemed appropriate for my child's health and safety. I understand that this permission is valid for the duration of the school year unless the nurse is informed by my child's provider or myself that it has been discontinued and I understand that changes to medication require a new action plan to be completed.

Parent/Guardian Signature:____**Date:**________________

Printed Name: ____

Daytime Phone Number: ____

Emergency Contact: ____

Phone Number: ____

Desoto Independent School District
Health Services 2019-2020
Seizure Action Plan

Emergency Contact: ____

Phone Number:____