SEIZURE ACTION PLAN (SAMPLE)

Effective Date

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student's Name: Date of Birth:

Parent/Guardian: Phone: Cell:

Treating Physician: Phone: _____________

Significant medical history:

INFORMATION:

Seizure Type	*Average length*	*Description*

Average frequency:

Seizure triggers or warning signs:

Student's reaction to seizure:

ASIC FIRST AID: CARE & COMFORT: *(Please describe basic first aid procedures)*

Basic Seizure First Aid:

- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth

Does student need to leave the classroom after a seizure? YES NO

RESPONSE:

ECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: