Mecklenburg County Health Department
School Health Program

SEIZURE EMERGENCY ACTION PLAN Name: ____

School: **Elizabeth Lane Elementary** Year: __________ Grade: _____ Date of Birth: _______________ Allergies: _____________

Homeroom Teacher: ___________________________________ Room: __________ Student ID #: __________________________

Parent/Guardian: ____ Ph. (H): ___________________________________

Address: ____ Ph. (W): ___________________________________

Parent/Guardian: ____ Ph. (H): ___________________________________

Address: ____ Ph. (W): ___________________________________

Emergency Phone Contact #1: _________________________________ _______________ ____________________
Name Relationship Phone

Emergency Phone Contact #2: _________________________________ _______________ ____________________
Name Relationship Phone

Physician treating student for seizure disorder : _______________________________ Phone: _____________________________

Other Physician: ____ Phone: ___________________________________

Preferred Hospital: ____

EMERGENCY PLAN

(Fill in blanks, cross out and initial any steps not needed for this student.)

Emergency action is necessary when the student has the following symptoms: ______________________________

____

Steps to take during a seizure:

1. Stay with student during and after seizure. Note duration of seizure and type of body movement during seizure episode.

2. Assist to lying position if loss of consciousness occurs. Remove glasses if wearing, loosen clothing around neck.

3. Turn on side as soon as possible.

4. Clear area around child to prevent injury; remove other students from area if possible.

5. **DO NOT RESTRAIN MOVEMENT OR PLACE ANYTHING IN MOUTH.**

6. Monitor breathing and begin artificial respiration if breathing does not resume spontaneously.

7. Call 911 if seizure lasts longer than 5 minutes, the student has one seizure after another without waking or there are signs of significant injury or physical/respiratory distress. If 911 is called, transport to ____Hospital.

8. When seizure is over, allow child to rest and always notify parent/guardian.

9. Notify school nurse.

Other instructions for this student: ____

____

Daily Seizure Management Plan:

1. What type of seizures does your child have and how often do they occur? ______________________

   ____

   Date of last seizure: ____

2. Describe your child's symptoms during and after a seizure episode. ___________________________

   ____

3. Does your child have an aura or warning of a seizure coming? Yes __ No __

   Is he/she able to notify anyone that a seizure is coming? Yes __ No __

4. Name medications taken routinely. How often and how much?

   At home: ____

   At school: ____

   Does your child experience any side effects to these medications? Please list:

   ____

   Are there any sports/activities in which your child CANNOT participate?

   ____

*** PLEASE NOTE: If medications are to be taken at school, a Medication Authorization form must be completed by the parent and physician and kept at the school.**

Parent/Guardian Signature: ____ Date: ______________

School Nurse Signature: ____ Date: ______________

<u>This information will be shared with appropriate school staff unless you state otherwise.</u>