



Emergency Action Plan

SEIZURE DISORDER



Student: _____ Grade: _____ DOB: _____ Bus #: _____/Car Rider: _____

Aura or sign seizure is coming: _____ Last Known Seizure: _____

Daily Medications: _____ School Year: _____ School: _____ Teacher: _____

SYMPTOMS OF A SEIZURE EPISODE MAY INCLUDE ANY/ALL OF THESE:

☐ **Tonic-Clonic Seizure: Grand mal**

- Entire body stiffens, jerking movements
- May cry out, turn bluish, be tired afterwards
- Clenched jaw
- Stop Breathing
- Headache
- Loss of Consciousness
- Incontinence(Loss of Bladder Control)

☐ **Absence Seizure: Petit mal**

- Staring spell, may blink eyes(eye fluttering)
- Hand twitching
- Lip Smacking
- Absence Spells
- Often mistaken for lack of attention
- Stop talking Abruptly
- Alert after spell

First Aid for Seizure Activity:

- ♦ Ease the student to the floor and clear the area around the student to avoid injury.
- ♦ DO NOT PUT ANYTHING IN THE STUDENT'S MOUTH OR RESTRAIN MOVEMENTS.
- ♦ Place student on side if possible, speak to student in reassuring tone
- ♦ Stay with student until help arrives
- ♦ Begin treatment and note time seizure activity started, kinds of movements or behaviors, what body parts are involved, and if loss of consciousness occurs and for how long.
- ♦ Notify school nurse/Emergency Response Team (First Responders)
- ♦ Notify parent/guardian (do not delay treatment)
- ♦ CALL 911 IF SEIZURE LASTS OVER 5 MINUTES or HAS ONE AFTER ANOTHER AT SHORT INTERVALS.

♦ **Emergency medication ordered**

☐ Yes ☐ No Type: _____ Location: _____

CALL 911 IF EMERGENCY MEDICATION GIVEN

- ♦ Begin CPR / Call 911 if breathing stops
- ♦ After seizure, keep airway clear by placing student on his/her side.
- ♦ Student should be allowed to rest following seizure
- ♦ Special Instructions: _____

* For Absence Seizures ONLY, contact parent/guardian and monitor.

Bus Transportation Plan: ☐ Medication available on Bus ☐ Medication **NOT** available on bus

Parent/Guardian Signature: _____ Date: _____

Emergency contact: _____ Phone:(w) _____ (c) _____

School Nurse Signature: _____ Date: _____

STAFF MEMBERS INSTRUCTED: ☐ Classroom Teacher(s) ☐ Special Area Teacher(s) ☐ Support Staff ☐ Transportation Staff



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