Penn Manor School District
Seizure Action Plan

Nurse's Office Direct Fax Number: 1-888-510-8011

Name: ______________________________DOB: ________ Grade: _____ School: _____________

SEIZURE INFORMATION			
Seizure Type	**Description**	**Length**	**Frequency**
Triggers/Warning Signs: ____			

Basic Seizure First Aid	Call 911/Seek Emergency Medical Attention if:
• Stay calm, remove bystanders • Keep child safe/Protect Head • Time the length of seizure, observe activity and record observations • Do not restrain/put anything in mouth • Stay with child until fully conscious • Notify nurse immediately for any seizure activity to determine next step(s) **For tonic-clonic (grand mal) seizures:** • Keep airway open/watch breathing • Turn child on side • Other: _______________________ ______________________________	• Generalized seizure lasts longer than 5 minutes • Student has ____ serial seizures without regaining consciousness • Student is injured or has Diabetes • Student's breathing and/or pulse have not returned to baseline • Student has seizure in water • Student has a first-time seizure • Other: __________________________ _________________________________

TREATMENT PROTOCOL DURING SCHOOL HOURS		
Daily Medication	**Dosage/Route**	**Time to Administer/Special Instructions**
Emergency Medication	**Dosage/Route**	**Time to Administer/Special Instructions**
Should emergency medication be administered, 911 will be called, unless otherwise specified by healthcare provider. Hospital Preference: ____		

TURN OVER TO COMPLETE THE BACK. SIGNATURES REQUIRED ON THE BACK

Vagus Nerve Stimulator (VNS)? ☐ Yes ☐ No **Other Device: _______________________**

Device Instructions: ____

____

____

OTHER ACCOMMODATIONS AND PRECAUTIONS (Regarding physical education, sports, field trips, or other school activities): ____

____

____

____

PARENT WILL BE NOTIFIED BY NURSE FOR ALL SEIZURE ACTIVITY (Unless otherwise specified by parent): ____

____

____

____

SIGNATURES

Healthcare Provider

Name ____________________ Signature __________________ Date_______ Phone (___) _____-_______

Parent/Guardian

Name ____________________ Signature __________________ Date_______ Phone (___) _____-_______

Signing verifies that you, the parent/guardian, give permission for the school staff to carry out the administration of the above prescribed plan in your absence, acknowledges that the school is not responsible for ensuring the medication is taken, and relieves the Board and its employees of responsibility for the benefits or consequences of such medication and its administration. I give permission to the doctor, school nurse, and other health care providers to share information about my child's seizure disorder to help improve the health of my child.

Emergency Contact #2 _____________________ Relationship __________ Phone (____) _____-_______