SEIZURE ACTION PLAN

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:____

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Seizure: ____

Note: Tonic-clonic seizure: Entire body stiffens, jerking movements, may cry out, turn blue, tired afterwards.

Absence seizure: Staring spell, may blink eyes

Seizure triggers or warning signs: _____________________Student's reaction to seizure:___________________

BASIC FIRST AID: CARE & COMFO RT :

______________________seizure:

Protect head from injury

Keep airway open/watch breathing

Turn child on side