



CONROE

INDEPENDENT SCHOOL DISTRICT
Committed to Excellence

Seizure Action Plan

School Year 20___/20___

(To be completed by treating healthcare provider)

Name: _____ Student ID: _____ DOB: ____/____/____

Seizure triggers or warning signs: _____

CISD staff will **administer medication(s)** as prescribed, **call 911 for emergency medication administration**, and **notify parents** of action plan initiation.

MEDICATION(S)/TREATMENT

Daily medication: _____

_____ (include dose, time, and route)

- Emergency medication: **call 911**
- Diastat® _____ mg rectally as needed for seizure > _____ minutes OR _____ seizures in _____ hours

Other: _____

_____ (include dose, time, and route)

- Vagus Nerve Stimulation (VNS): **call 911 at 5 minutes**
- Swipe magnet at seizure onset
- Swipe for report of aura
- Repeat swipe _____ times every _____ minutes if seizure persists
- Other: _____

SEIZURE DESCRIPTION

Seizure type: _____

Seizure description: (check all that apply)

- Convulsions Involuntary rhythmic movements
- Staring Unconsciousness
- Stiffening Facial tics

(other information, including average length, frequency, and observations): _____

Does student need to leave the classroom after a seizure:
YES NO If YES, describe process for returning student to classroom.

SEIZURE FIRST AID

- Stay calm and contact the school nurse
- Track seizure start time
- Do not restrain or remove from wheelchair (unless emergency medication must be administered)
- Do not put anything in mouth
- Remain with student
- Protect head

EMERGENCY SEIZURES (call 911)

- Seizure lasting longer than 5 minutes
- Student does not regain consciousness
- Student has a first time seizure
- Student is injured or has diabetes
- Student has difficulty breathing
- Student has a seizure in water

Printed name of HCP

Signature of HCP

(____) _____ - _____
Phone number

____/____/20____
Date

I agree with the recommendations of my child's HCP and authorize CISD staff to deliver treatment as outlined above. I also give permission for my child's HCP to communicate with appropriate CISD employees regarding this seizure action plan for the current school year.

Printed name, parent/guardian

Signature parent/guardian

(____) _____ - _____
Phone number

____/____/20____
Date