Seizure Action Plan 2024-2025 School Year

This form is only valid for the 2024-2025 School Year

Child's Last Name:_____ Child's First Name:_____

Child's Date of Birth: _____ Diagnosis: _____

Parent/Guardian #1 Name: _____ Phone: _____

Parent/Guardian #2 Name: _____ Phone: _____

Seizure History

Frequency of Seizures: _____

Date of Last Seizure: _____

Signs/Symptoms of Seizure: _____

_____

Treatment Required for Previous Seizures: _____

_____

Action Plan

If _____has a seizure while at High Hopes, in addition to contacting a parent/guardian immediately, I would like the following steps to be taken:

☐ Call 911 immediately. Monitor vital signs and document signs and symptoms until emergency medical assistance arrives.

☐ Give the following medication according to physician orders and call 911. Physician instructions must be provided to the teacher and a Permission to Medicate form completed and on file.

Seizure Rescue Medication: _____

Route: _____

Dosage: _____

When to Give: _____

☐ Call parent/guardian and discuss whether signs and symptoms warrant emergency medical assistance. Staff members will continue to monitor vital signs and, should they deteriorate, will call 911.

☐ Other: _____

Parent/Guardian Signature:_____ Date: _____

Neurologist Name: _____ Phone: _____

Neurologist Signature:_____ Date:_____

Nurse's Signature: _____Date: _____