Springs CHARTER SCHOOLS
HEALTH SERVICES DEPARTMENT

Seizure Action Plan

Effective Date: _____

Student Name: _____ DOB: _____ Grade: _____

Site/Program: _____

Parents/Guardian Information:	Relationship:	Phone Number(s):
1)		
2)		

I give permission for my child's school site/nurse to notify appropriate staff members of my child's diagnosis, as well as give permission for the school to implement this plan of care for my child, and that any medical orders supersede district plans.

Parent/Guardian Signature: _____ Date: _____

This portion to be completed by Physician

SEIZURE INFORMATION			
Seizure Type	**Length**	**Frequency**	**Description**
Seizure triggers or warning signs:		Student's response after a seizure:	

Student may carry emergency seizure medication: ☐Yes ☐No

Does the student need to leave the classroom after a seizure? ☐ Yes ☐ No

If YES, describe process for returning student to classroom:_____

EMERGENCY RESPONSE	
A "seizure emergency" for this student is defined as: ***If the seizure is longer than 5 minutes CALL 911***	**Seizure Emergency Protocol** • Call 911 for transport to _____ • Notify parent or emergency contact • Notify doctor Other:

Treatment Protocol During School Hours (include daily and emergency medications)			
Emerg Med?	**Medication Name**	**Dosage & Time of Day Given**	**Common Side Effects & Special Instructions**
☐			
☐			

Does the student have a Vagus Nerve Stimulator? ☐ Yes ☐ No

If YES, describe magnet use: _____

Special Considerations and Precautions (regarding school activities, sports, trips, etc.) ☐ Yes ☐ No

Describe any special considerations or precautions: _____

Physician Name (printed): _____ Phone Number: _____

Physician Signature: _____ Date: _____ License #:_____

Return Fax: 951-489-0494 or Email: school.nurse@springscs.org