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NRS 1035-3/23

Bellevue Public Schools

Seizure Action Plan

Student information

Student's name _____ Date of Birth _____

School _____ Grade _____

Please complete this form with current information about your student's seizure disorder, including actions to take should a problem arise. A new action plan is required each school year to be completed on or after May 1.

Contact information

Parent/Guardian 1 _____

Telephone Home _____ Work _____ Cell _____

Email address _____

Parent/Guardian 2 _____

Telephone Home _____ Work _____ Cell _____

Email address _____

Student's physician/health care provider _____

Address _____

Telephone _____ Fax _____

Age at diagnosis of seizure disorder: _____ Drug allergies: _____

1. Current daily seizure medications, dosages and times given: _____
   _____
2. What kind of seizure does your student experience: (**please circle**)
   A. Tonic Clonic (Grand Mal) B. Absence (Petit Mal) C. Partial: Simple or Complex
   D. Other, or describe seizure _____
   _____
3. Date of your student's last seizure: _____
4. Average length of seizure: _____
5. How often do seizures occur? _____
6. If a seizure occurs during school hours, what procedures do you want us to follow? _____
   _____
7. If your student's seizures are infrequent, we will notify you when one occurs. If, however, your student's seizures are frequent, when do you wish to be notified? _____
   _____
8. Is there any other information you wish to share regarding your student's seizure disorder? (i.e., activity restrictions or seizure triggers) _____
   _____
9. Does your student have emergency medication prescribed for seizures? ☐ Yes ☐ No
   If yes, please list emergency medication: _____
10. Does your student have a Vagus Nerve Stimulator? ☐ Yes ☐ No
    If yes, describe magnet use: _____
    _____
11. Does your student wear a helmet? ☐ Yes ☐ No

If medication is required at school, please provide the medication with the "Permission for Administration of Medication by School Personnel" form.

PLEASE COMPLETE BACK OF PAGE

Seizure Action Plan _____

Student's Last Name Student's First Name

Tonic Clonic (Grand Mal) Seizure First Aid

- Stay calm and track time.
- Keep student safe and protect the head.
- Turn the student on their side.
- Do not put objects in their mouth.
- Do not restrain the student.
- Stay with student until fully conscious.
- Notify school nurse and parent/guardian.

Caution: 911 EMS should be called if:

- The seizure lasts longer than **5 minutes**.
- The student does not return to consciousness.
- Repeated seizures occur.
- The student is injured, pregnant, or sick.
- If the seizure occurs in water.
- The student has difficulty breathing.
- The parent/guardian requests.
- Emergency medication is administered.

_____

Partial (Simple or Complex) and Absence Seizure First Aid

- Stay calm and track time.
- Keep student safe.
- Do not put objects in their mouth.
- Do not restrain the student.
- Stay with student until fully conscious.
- Notify school nurse and parent/guardian.

Additional comments: _____

_____

_____

_____

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_____

I understand and agree this information will be reviewed by the school nurse and shared with school staff when appropriate. The school nurse may contact you or your student's physician/health care provider if additional information or clarification is needed. I authorize the school nurse or designated personnel to follow this seizure action plan and administer medications as detailed in this plan.

Physician signature_____ Date_____

Parent/Guardian signature_____ Date_____

Reviewed by school nurse_____ Date_____

_____

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