



**SEIZURE ACTION PLAN**

Effective Date \_\_\_\_\_

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: \_\_\_\_\_

**SEIZURE INFORMATION:**

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: \_\_\_\_\_

Student's reaction to seizure: \_\_\_\_\_

**BASIC FIRST AID: CARE & COMFORT:** (Please describe basic first aid procedures)

Does 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: \_\_\_\_\_

**Basic Seizure First Aid:**

- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

**For tonic-clonic (grand mal) seizure:**

- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

**Seizure Emergency Protocol:** (Check all that apply and clarify below)

- ☐ Contact school nurse at \_\_\_\_\_
- ☐ Call 911 for transport to \_\_\_\_\_
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other \_\_\_\_\_

**A Seizure is generally considered an Emergency when:**

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

**TREATMENT PROTOCOL DURING SCHOOL HOURS:** (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication \_\_\_\_\_

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use \_\_\_\_\_

**SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS:** (regarding school activities, sports, trips, etc.)

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Conroe ISD Questionnaire for Parent or a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and for providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

## Contact information

Student's name \_\_\_\_\_ Date of birth \_\_\_\_\_  
School year \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_ Classroom \_\_\_\_\_  
Parent/guardian name \_\_\_\_\_  
Telephone numbers (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_  
Other emergency contact (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_  
Child's neurologist (name) \_\_\_\_\_ (telephone) \_\_\_\_\_  
(location) \_\_\_\_\_  
Child's primary care doctor (name) \_\_\_\_\_ (telephone) \_\_\_\_\_  
(location) \_\_\_\_\_  
Significant medical history or conditions \_\_\_\_\_

## Seizure information

When was your child diagnosed with seizures or epilepsy? \_\_\_\_\_

Seizure type(s) \_\_\_\_\_

Seizure type	Length	Frequency	Description

What might trigger a seizure in your child? \_\_\_\_\_

Are there any warnings and/or behavior changes before the seizure occurs? ..... ☐ yes ☐ no

If yes, please explain \_\_\_\_\_

When was your child's last seizure? \_\_\_\_\_

Has there been any recent change in your child's seizure patterns? ..... ☐ yes ☐ no

If yes, please explain \_\_\_\_\_

How does your child react after a seizure is over? \_\_\_\_\_

How do other illnesses affect your child's seizure control? \_\_\_\_\_

## Basic first aid: Care and comfort measures

What basic first aid procedures should be taken when your child has a seizure in school?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Basic Seizure First Aid**

- Stay calm and track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

**For tonic-clonic (grand mal) seizure:**

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Will your child need to leave the classroom after a seizure? ..... ☐ yes ☐ no

If yes, what process would you recommend for returning your child to the classroom \_\_\_\_\_



Please describe what constitutes an emergency for your child.  
(Answer may require a consultation with treating physician and school nurse)

A seizure is generally considered an emergency when:

- A convulsive (tonic-clonic) seizure lasts longer than five minutes
- Student has repeated seizures without regaining consciousness
- Student has a first-time seizure
- Student is injured or diabetic
- Student has breathing difficulties
- Student has a seizure in water

Has the child ever been hospitalized for continuous seizures? ..... ☐ yes ☐ no

If yes, please explain \_\_\_\_\_

**Seizure medication and treatment information** \_\_\_\_\_

What medication(s) does your child take?

Medication	Date started	Dosage	Frequency and time of day taken	Possible side effects

What emergency /rescue medications are prescribed for your child?

Medication	Dosage	Administration instructions (timing* & method**)	What to do after administration

\* After 2nd or 3rd seizure, for cluster of seizures, etc.      \*\* Orally, under tongue, rectally, etc.

What medication(s) will your child need to take during school hours? \_\_\_\_\_

Should any of these medications be administered in a special way? ..... ☐ yes ☐ no

If yes, please explain \_\_\_\_\_

Should any particular reaction be watched for?..... ☐ yes ☐ no

If yes, please explain \_\_\_\_\_

What should be done when you child misses a dose? \_\_\_\_\_

Should the school have a backup medication available to give your child for a missed dose? ..... ☐ yes ☐ no

Do you wish to be called before backup medication is given for a missed dose? ..... ☐ yes ☐ no

Does your child have a Vagus Nerve Stimulator? ..... ☐ yes ☐ no

If yes, please describe instructions for appropriate magnet use \_\_\_\_\_

**Special considerations and precautions** \_\_\_\_\_

Check all that apply and describe any considerations or precautions that should be taken

- ☐ General health \_\_\_\_\_
- ☐ Physical functioning \_\_\_\_\_
- ☐ Learning \_\_\_\_\_
- ☐ Behavior \_\_\_\_\_
- ☐ Mood / coping \_\_\_\_\_
- ☐ Recess \_\_\_\_\_
- ☐ Field trips \_\_\_\_\_
- ☐ Bus transportation \_\_\_\_\_
- ☐ P.E./sports \_\_\_\_\_
- ☐ Other \_\_\_\_\_

**General communication issues** \_\_\_\_\_

What is the best way for us to communicate with you about your child's seizure(s)? \_\_\_\_\_

Can this information be shared with classroom teacher(s) and other appropriate school personnel? ..... ☐ yes ☐ no

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent/guardian signature

Date

Date updated

Date updated

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