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Kirtland Local Schools – Individualized Seizure Action Plan

Student Name: _____ Birthdate: _____
Address: _____ Phone Number: _____
Emergency Contact/Relationship: _____ Phone Number: _____

SEIZURE INFORMATION

SEIZURE TYPE	HOW LONG IT LASTS	HOW OFTEN	WHAT HAPPENS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOW TO RESPOND TO A SEIZURE

☐ First Aid (Stay, Safe, Side) ☐ Give Rescue Therapy According To Plan ☐ Notify Emergency Contact

☐ Call 911 ☐ Other _____

FIRST AID FOR ANY SEIZURE

__ STAY calm, keep calm, begin timing seizure.
__ Keep the student SAFE – remove harmful objects, don't restrain, protect his/her head.
__ Turn the student on their SIDE if not awake, keep the airway clear, do not put objects in his/her mouth.
__ STAY with the student until he/she is recovered from the seizure.
__ Write down what happens: _____

WHEN TO CALL 911

☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue medicine, if available.
☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue medicine, if available.
☐ Difficulty breathing after seizure.
☐ Serious injury occurs or suspected, or seizure is in water.

WHEN RESCUE THERAPY MAY BE NEEDED

If seizure is (cluster, number, or length): _____
Name of medicine/prescription: _____ Dose: _____
How to give: _____

If seizure is (cluster, number, or length): _____
Name of medicine/prescription: _____ Dose: _____
How to give: _____

☐ It is the parent's request to have the above seizure disorder prescriptions, prescribed by the doctor, administered to the student.

Parent Signature: _____ Date: _____
Doctor Signature: _____ Date: _____

CARE AFTER SEIZURE

What type of help is needed? _____
When is the student able to resume their usual activity? _____

SPECIAL INSTRUCTIONS

First Responders: _____
_____

Emergency Department: _____
_____

DAILY SEIZURE MEDICINE

MEDICINE	TOTAL DAILY AMOUNT	AMOUNT OF TABLET/LIQUID	TIME OF EACH DOSE	HOW TAKEN
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

☐ It is the parent's request to have the above seizure disorder prescriptions, prescribed by the doctor, administered to the student.
Parent Signature: _____ Date: _____
Doctor Signature: _____ Date: _____

OTHER INFORMATION

Triggers: _____
Important Medical History: _____
_____
Allergies: _____
Epilepsy Surgery: _____
Diet Therapy: ☐ Ketogenic ☐ Low Glycemic ☐ Modified Adkins ☐ Other _____

Special Instructions: _____

HEALTH CARE CONTACTS

Epilepsy Provider: _____ Phone Number: _____
Primary Care: _____ Phone Number: _____
Preferred Hospital: _____ Phone Number: _____
Pharmacy: _____ Phone Number: _____

Parent Signature: _____ Date: _____
Doctor Signature: _____ Date: _____