Nixa School District Health Services
Seizure Action Plan

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

Student Name ______________________________ DOB ____________ School Year ________________

School __________________________ Grade __________ Teacher/Homeroom ____________________

Parent/Guardian _______________________Cell_____________Home____________Work __________
Emergency Contact _____________________Cell_____________Home____________Work__________

Neurologist ____________________________________Telephone______________Fax______________
Address____

Primary Care Physician___________________________Telephone______________Fax______________
Address____

Significant medical history:

____
____
____

Seizure Information

Seizure Type(s)	Average Length	Description
1.____________________	________________	______________________________
2.____________________	________________	______________________________
3.____________________	________________	______________________________

1. When was you child diagnosed with seizures or epilepsy?
   ____
2. What might trigger a seizure in your child?
   ____
3. Are there any warning and/or behavior changes before the seizure occurs? ____YES ____NO
   If yes, please explain ____
4. How often does your child have seizures?
   ____
5. When was your child's last seizure?
   ____
6. Has there been any recent changes in your child's seizure patterns? ____YES ____NO
   If yes, please explain ____
7. How does your child react after a seizure is over?
   ____
8. How do other illness affect your child's seizure control?
   ____
9. 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 classroom (if applicable)?
   ____
10. Please give any additional information you would like us to have regarding your child's seizure history:
    ____
    ____

Special Considerations and Precautions

Student Name:____________________
Student DOB:____________________

Please list any care and comfort measures you suggest for your child during and after a seizure.

____

General Communication Issues

What is the best way for us to communicate with you about your child's seizures?

____

Seizure Emergencies

A seizure is generally considered an emergency when the activity lasts longer than 5 minutes, the student has repeated seizures without regaining consciousness, the student is injured, the student has breathing difficulties or the student has no known history of seizures.

Please describe what constitutes an emergency for your child?

____
____
____

Emergency Rescue Medications Prescribed

Name	Dosage	Administration Instructions	Timing and Method

Emergency Response:
In the event that your child is experiencing a seizure-related emergency, the school nurse or staff will:

- Call 911 - Do you have a preferred Hospital? ____________________
- Administer emergency medications indicated above, if available.
- Notify parent or emergency contact

Other: ____

Seizure Medication and Treatment Information

Prescribed Medication	Date Started	Dosage	Frequency/Time of Day	Possible Side Effects

1. What medication(s) will your child need to take during school hours?

   ____
2. Should any of these medications be administered in a special way? ____ YES ____ NO
   If yes, please explain____
3. Should we monitor for any particular reaction? ____ YES ____ NO
   If yes, please explain____
4. Does your child have a Vagus Nerve Stimulator? ____ YES ____ NO
   If yes, please describe instructions for appropriate magnet use

   ____

Parent's Signature ______________________________ Date ________________

Physician's Signature______________________________ Date ________________