

Seizure Action Plan

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

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol

(check all that apply and number order of protocol)

- ☐ Administer emergency medications as indicated below
- ☐ 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	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a Vagus Nerve Stimulator?

- ☐ Yes If YES, describe magnet use:
- ☐ No

Authorization PRN

- ☐ Authorization to Administer PRN Fever/Pain medication
Attach Lakeview School Form 344 or a Prescription Rx

Special Considerations and Precautions (regarding school activities, trips, etc.)

Describe any special considerations or precautions:

Print Physician Name/Stamp

Physician Signature

Date

Parent/Guardian Signature

Date