SEIZURE ACTION PLAN **School Year**:_____

Hillsborough City School District
300 El Cerrito Avenue, Hillsborough CA 94010
(650) 342-5193 • FAX (650) 342-6964

School:_____

School Fax:_____

This student is being treated for a seizure disorder. The information below may assist if a seizure occurs during school hours or at school activities.

Student Name:_____ DOB:_____
Parent/Guardian: _____ Phone: _____ CELL: _____
Primary Physician: _____ Phone: _____ FAX: _____
Neurologist: _____ Phone: _____ FAX: _____

PHYSICAN COMPLETES FORM FROM THIS POINT FORWARD.

Significant Medical History: _____

Seizure Type	Length	Frequency	Description	Date of Last Seizure

Seizure triggers or warning signs**:** _____

SEIZURE BASIC ➔ ➔ ➔	**SEIZURE RESPONSE - BASIC**
Student Response after a Seizure: _____ _____ _____ Does student need to leave classroom after a seizure? ☐Yes ☐No If YES, describe process for returning student to classroom: _____ _____ _____	• Stay calm and record time of seizure • Keep student safe but DO NOT restrain • Do not put anything in mouth • Stay with student until fully conscious • Document ending time and description of seizure ***Tonic-Clonic Seizure additional response:*** • Protect Head • Turn on Side • Keep Airway Open • Monitor Breathing

SEIZURE EMERGENCY	**SEIZURE EMERGENCY CALL 911** ➔	**SEIZURE RESPONSE - EMERGENCY**
A 'Seizure Emergency' for this student is defined as: _____ _____ _____ _____	• Convulsive (tonic-clonic) seizure lasts longer than 5 minutes • Student has repeated seizures without regaining consciousness • Student is injured, has diabetes, or is pregnant • Student has first time seizure • Student has breathing difficulties • Student has a seizure in water	• **Call 911 after _____ minutes** • Contact school office / school. • Administer emergency medications, **if ordered**. • Office to notify parents/guardian or emergency contact on ER card. Other: _____

In case of disaster, a 3-day supply of medications must be provided.

Daily Medication:	Dosage & Time Given:	Common Side Effects & Special Instructions

Emergency Medication: If prescribed, go to your school site office and get the Emergency Anti-Seizure Forms

Does student have a Vagus Nerve Stimulator? ☐Yes ☐No If YES, provide VNS protocol.

Special Considerations and Precautions (regarding school activities, swimming, helmet use, or bus riding after seizure, etc.)

_____

Physician Signature: _____ PRINTED NAME:_____ DATE: _____

This form authorizes medication to be given during school hours, on extended field trips or in the incidence of a public disaster i.e., earthquake. I consent to communication and exchange of information between my physician and Hillsborough City School District staff to discuss and share records/conditions pertaining to the above. I understand that this information is confidential and may not be given to employees of other schools, public agencies or individual professionals in private practice without my consent. Ed Code 49480

This Form Must Be Renewed Annually Or With Any Change In Treatment Or Medication.

Parent/Guardian Signature: _____ Date: _____