Lexington Public Schools
SEIZURE ACTION PLAN

NAME _____ GRADE _____ AGE _____ SCHOOL _____

Parents/Guardian Name_____
Phone: (home)_____ Phone: (work)_____
Parents/Guardian Name _____
Phone: (home)_____ Phone: (work)_____
Emergency Contact _____ Phone _____
Emergency Contact _____ Phone _____

When was your child's last seizure?_____
What might trigger a seizure in your child?_____
Are there any warnings and/or behavior changes before the seizure?_____
Signs & Symptoms of your child during the seizure:
☐ lips smacking together ☐ twitching of arms, legs, fingers ☐ eyes rotate ☐ rigid arms, legs, or body ☐ full body contractions ☐ disorientation ☐ loss of consciousness ☐ loss of bladder control
How long do the seizures usually last?_____

Medications:

☛ PARENTS ARE RESPONSIBLE TO HAVE NECESSARY MEDICATIONS AT SCHOOL FOR STUDENT TO USE!!

Routine medications used at home or school:

Name of Medicine	How Much	When

ACTION PLAN for school staff:

1. At start of seizure, attempt to prevent injury by **easing student to floor**. Keep hard, sharp or hot objects out of the way.
2. **Turn student to the side** to allow saliva to drain and to prevent choking.
3. **Do not restrain**. You may place a thin soft towel or item under the head if the floor is hard.
4. **Do not force anything between teeth or place any object in the mouth**. **Do not give fluids or food to student**.
5. Note the length of seizure. **If the seizure lasts longer than 5 min., if he/she is not breathing, or if they do not regain consciousness after the seizure, call 911 immediately**.
6. Notify the school nurse and parents.
7. **Do not attempt to move the person** until the seizure is over.
8. When possible, a seat belt should be worn on the bus. If the **student should seizure while on the bus, call 911 immediately**.

Comments or Special Instructions:_____
_____

SPECIAL CONSIDERATIONS & PRECAUTIONS: Check all that apply & describe measures that should be taken:
☐ General Health _____ ☐ Physical functioning _____
☐ Learning _____ ☐ Recess _____
☐ Behavior _____ ☐ Field Trips _____
☐ Mood/Coping _____ ☐ Bus Transportation _____
☐ Other _____

I understand school personnel will follow this plan and, if necessary, will call 911. I give Lexington Public School Nursing Staff permission to contact Dr._____, or prescribing physician, regarding any seizures or the action plan.

_____
Parent/Guardian Signature Date