


_____ 's Seizure Action Plan DOB: _____ Classroom/Homeroom _____
 Student's Name

1 Parent/Guardian: _____ Phone (w): _____ (c): _____ (h): _____
 2 Parent/Guardian: _____ Phone (w): _____ (c): _____ (h): _____

Physician: _____ Phone: _____ Fax: _____

SEIZURE INFORMATION			
Seizure Type	Length	Frequency	Description
Seizure Triggers or warning signs:		Response after seizure:	
Special Considerations and Precautions: (activities, trips...)		Dietary Adjustments due to medication: (Complete Diet Order if needed)	
Medications:			
TREATMENT			
<input type="checkbox"/> Absence <input type="checkbox"/> Atonic <input type="checkbox"/> Complex Partial <input type="checkbox"/> Infantile Spasms	<ol style="list-style-type: none"> Stay with the student during and after the seizure. Although the student may appear conscious, he/she may lose awareness of surroundings. Be prepared to assist student to the floor if he loses consciousness. Time seizures and watch for clusters. Document seizure in log. Notify parent: _____(Notebook) _____(phone) _____(email) _____(text) Special Instructions:		
<input type="checkbox"/> General Tonic/Clonic	<ol style="list-style-type: none"> Do not restrain movement. Let the seizure run its course. Turn student on side. Loosen the student's collar. Do not place anything in the mouth. Remove hard, sharp objects from the area. If possible, turn head to the side in the event he/she vomits. (Use "Universal Precautions" if student vomits.) Observe, note time, and be prepared to describe the pattern of the seizure. Record details as they occur or as soon as possible thereafter. Notify parent : _____(Notebook) _____(phone) _____(email) _____(text) When seizure is over, allow the student to rest. Stay with the student until fully recovered or parent arrives. 		
Administer Emergency Medication:	Diastat Order: _____ Versed Order: _____ Vagus Nerve Stimulator? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Location of VNS: _____ Swipe after _____ min. Repeat Swipe if: _____(Please include max number of times to swipe)		
Call 911! 	Call 911 if: <ul style="list-style-type: none"> The seizure lasts more than _____ minutes, or The student has a continuous seizure, or cluster of \geq _____ seizure(s) The student remains unconscious after the seizure, or He or she is having difficulty breathing, or Any injury resulted from the seizure. _____ 		

❖ **Physician's signature required:** _____ Date: _____

I give permission to school staff to give the medication listed above as instructed, and contact MD for questions.

Parent / Guardian Signature: _____ Date: _____

Attach additional instructions as applicable.

Student's Name: _____

Date: _____

Teaching Log for Vagus Nerve Stimulator (VNS)

please check off each item covered

The teaching session should include:

- *How a vagus nerve stimulator works to stop a seizure.*
- *Signs and symptoms of seizure activity in this student.*
- *At what point in seizure activity is the VNS used.*
- *Number of times magnet should be swiped (according to physician's order)*
- *Locations of VNS in chest wall*
- *Location of VNS magnetic wand*

Description of Procedure for VNS Administrations

_____ *Observe child for seizure activity*

_____ *Time seizure*

_____ *Activate VNS by moving the magnetic wand across vagus nerve stimulator according to physician's order*

_____ *Call 911 for seizure lasting longer than 5 minutes (or according to Physician's order), respiratory distress or unresponsiveness following seizure.*

_____ *Notify parent*

Nurse Instructor Name: _____

Staff Sign In:

<u>Name</u>	<u>Signature</u>	<u>Date</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____