

SEIZURE ACTION PLAN
Woodside School District
 3195 Woodside Rd.
 Woodside CA 94062
 650-851-1571

School Year _____

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: _____

PHYSICIAN 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, describe process for returning student to classroom: _____ _____ _____	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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: _____ _____ _____ _____	<ul style="list-style-type: none"> 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 a first time seizure Student has breathing difficulties Student has a seizure in water 	<ul style="list-style-type: none"> Call 911 after _____ minutes Contact school office / school nurse 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

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 Palo Alto Unified School District 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: _____