CONROE INDEPENDENT SCHOOL DISTRICT
Committed to Excellence

Seizure Action Plan
School Year 20____/20_____
(To be completed by treating healthcare provider)

Name: _____ Student ID: _____ DOB: _____/_____/_____
Seizure triggers or warning signs: _____
_____

CISD staff will **administer medication(s)** as prescribed, **call 911 for emergency medication administration**, and **notify parents** of action plan initiation.

MEDICATION(S)/TREATMENT

Daily medication: _____

_____
(include dose, time, and route)

[ ] Emergency medication: **call 911**
[ ] Diastat® _____ mg rectally as needed for:
seizure > _____ minutes OR
_____ seizures in _____ hours
[ ] Other: _____
_____

_____
(include dose, time, and route)

[ ] Vagus Nerve Stimulation (VNS): **call 911 at 5 minutes**
[ ] Swipe magnet at seizure onset
[ ] Swipe for report of aura
[ ] Repeat swipe _____times every _____ minutes if seizure persists
[ ] Other: _____

SEIZURE DESCRIPTION

Seizure type: _____
Seizure description: (check all that apply)

[ ] Convulsions [ ] Involuntary rhythmic movements
[ ] Staring [ ] Unconsciousness
[ ] Stiffening [ ] Facial tics

(other information, including average length, frequency, and observations):_____
_____
_____
_____

Does student need to leave the classroom after a seizure: YES NO If YES, describe process for returning student to classroom.
_____
_____
_____

SEIZURE FIRST AID

- Stay calm and contact the school nurse
- Track seizure start time
- Do not restrain or remove from wheelchair (unless emergency medication must be administered)
- Do not put anything in mouth
- Remain with student
- Protect head

EMERGENCY SEIZURES (call 911)

- Seizure lasting longer than 5 minutes
- Student does not regain consciousness
- Student has a first time seizure
- Student is injured or has diabetes
- Student has difficulty breathing
- Student has a seizure in water

_____ _____ (_____) _____-_____ _____/___/20____
Printed name of HCP Signature of HCP Phone number Date

I agree with the recommendations of my child's HCP and authorize CISD staff to deliver treatment as outlined above. I also give permission for my child's HCP to communicate with appropriate CISD employees regarding this seizure action plan for the current school year.

_____ _____ (_____) _____-_____ _____/_____/20_____
Printed name, parent/guardian Signature parent/guardian Phone number Date