

# **YOUTH Seizure Action Plan & Parent Questionnaire**

# CONTACT INFORMATION:

Nurse's Name:	Phone:		
Student's Name:			
School:	Grade:	Classroom:	
Parent/Guardian Name:	Tel. (H):	_(W):	(C):
Other Emergency Contact:	Tel. (H):	(W):	(C):
Child's Neurologist:	Tel:	Location:	
Child's Primary Care Dr.:	Tel:	Location:	
Significant medical history or conditions:			

#### SEIZURE INFORMATION:

Seizure	Туре
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Length Frequency Description

#### Seizure triggers or warning signs:

Response after a seizure:

### TREATMENT PROTOCOL: (include daily and emergency medications)

Emergency Med? <b>V</b>	Medication	Dosage & Time of Day Given	Route of Administration	Common Side Effects & Special Instructions

#### Does child have a Vagus Nerve Stimulator (VNS)? YES NO

If YES, describe magnet use\_

#### BASIC FIRST AID: CARE & COMFORT:

Please describe basic first aid procedures: \_\_\_\_

Does person need to leave the room/area after a seizure? YES NO If YES, describe process for returning: \_\_\_\_\_\_

#### EMERGENCY RESPONSE:

A "seizure emergency" for this person is defined as: \_\_\_\_\_

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Call 911 for	transport to
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Notify parent or	emergency	contact
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Notify doctor

Administer emergency medications as indicated below

#### Basic seizure first aid:

- Stay calm & track time
- Keep person safe
- Do not restrain
- Do not put anything in mouth
- Stay with person until fully conscious
- Record seizure in log

## For tonic-clonic (grand mal) seizure:

- Protect head
- Keep airway open/watch breathing
- Turn person on side

#### A seizure is considered an emergency when:

- A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- There are repeated seizures without regaining consciousness
- It's a first-time seizure
- The person is injured or has diabetes
- The person has breathing difficulties
- The seizure is in water



	Other				
SEI	ZURE INFORMATION:				
1.	When was your child diagnosed with epilepsy?				
2.	Will your child need to leave the classroom after a seizure? If YES, describe best process for returning your child to			NO	
3.	How often does your child have a seizure?				
4.	When was your child's last seizure?				
5.	Has there been any recent change in your child's seizure particular of YES, please explain:				NO
6.	How do other illnesses affect your child's seizure control?_				
7.	What medication(s) will your child need to take durin	ig sc	hool hou	rs?	
8.	Should any of these medications be administered in a If YES, please explain:	•			
9.	Should any particular reaction be watched for? YES If YES, please explain:				
10.	What should be done when your child misses a dose?	<u> </u>			
11.	Should the school have backup medication available	to gi	ve your c	hild for	missed dose? YES NO
12.	Do you wish to be called before backup medication is	giv	en for a n	nissed de	ose?
SPE	CIAL CONSIDERATIONS & PRECAUTIONS				
Che	eck any special considerations related to your child's e	pile	osy while	at schoo	J. (Check appropriate boxes and describe
the	impact of your child's seizures or treatment regimen)				
	General health:		Physical	educati	on (gym)/sports:
	Physical functioning:		Recess:		
	Learning:		Field tri	os:	
	Behavior:		Bus tran	sportati	on:

- □ Mood/coping:
- Other:

# GENERAL COMMUNICATION ISSUES

What is the best way for us to commu	nicate about your child's seizure(s)?:_			
Does school personnel have permission	on to contact your child's physician?	YES	NO	
Can this information be shared with cl	assroom teacher(s) and other approp	riate schoo	l personne	I? YES NO
Parent Signature:	Date:	Dates Up	odated	/
Physician Signature:	Date:			