

# Seizure Management and Treatment Plan Form

This form is designed to help create a plan for managing student seizures. It consists of questions about seizure history, medications, precautions, and other considerations. This form should be completed jointly by the student's parents and treating physician and provided to the campus nurse or other appropriately identified personnel.

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Emergency Contact/  
Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

## Seizure Information

Seizure Type	Length (How long it lasts)	Frequency (How often)	What Happens During a Seizure

## Known Seizure Triggers or Warning Signs

Missed Medicine      Emotional Stress      Lack of Sleep  
Physical Stress      Flashing Lights      Missing Meals  
Illness with High Fever      Alcohol/Drugs      Menstrual Cycle

Response to specific food or excess caffeine. Specify:

\_\_\_\_\_  
Other: \_\_\_\_\_

## VNS/Devices

Devices: VNS    RNS    DBS

Date Implanted: \_\_\_\_\_

Magnet Use/Instructions:

\_\_\_\_\_

### Basic first aid to be provided during a seizure

- **STAY** calm, keep calm, begin timing the seizure
- Keep the student **SAFE**: remove harmful objects, don't restrain, and protect their head
- Turn the student on **SIDE** if not awake, keep airway clear, don't put objects in mouth
- **STAY** until the student recovers
- **SWIPE** magnet for VNS
- Write down what happened during the seizure
- Other: \_\_\_\_\_

### When to call 911 - A seizure emergency for the student

- Seizure with a loss of consciousness longer than five minutes and not responding to rescue medicine if available
- Repeated seizures lasting longer than 10 minutes, with no recovery between them and the student is not responding to available rescue medicine
- Difficulty breathing after seizure
- Serious injury occurs or is suspected; seizure in water

### When to call student's doctor first

- A change in seizure type, number, or pattern
- Student does not return to usual behavior (i.e., confused for a long period)
- A first time seizure that stops on its own
- Other medical problems or a pregnancy needs to be checked

Student name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### Seizure Emergency Protocol for District Personnel to Follow

- Administer emergency medications \_\_\_\_\_
- Contact school nurse: \_\_\_\_\_
- Call 911; transport to \_\_\_\_\_
- Notify parent or emergency contact and doctor \_\_\_\_\_
- Other: \_\_\_\_\_

### When and What to Do When Rescue Therapy is Needed

If seizure (cluster, # or length): _____	If seizure (cluster, # or length): _____
Name of Med/Rx: _____	Name of Med/Rx: _____
How much to give (dose): _____	How much to give (dose): _____
How to give: _____	How to give: _____

### Student's Response and Care After a Seizure

What type of help is needed? \_\_\_\_\_

When is the student able to resume usual activity? \_\_\_\_\_

Does the student need to leave the classroom? Yes    No

    If yes, when can the student return to the classroom? \_\_\_\_\_

Is the student able to manage and understand their seizures? Yes    No

### Special Instructions

First Responders: \_\_\_\_\_

Emergency Department: \_\_\_\_\_

### Daily Seizure Medication

Medication Name	Dosage	Time to be Given	Common Side Effects	Special Instructions

### Other Information

Important medical history: \_\_\_\_\_

Allergies: \_\_\_\_\_

Epilepsy surgery (type, date, side effects): \_\_\_\_\_

Diet therapy: Ketogenic    Low-Glycemic    Modified Atkins    Other: \_\_\_\_\_

Special considerations, instructions, or precautions (i.e., school trips, activities, sports, etc.): \_\_\_\_\_

### Health Care Contacts

Epilepsy Provider: _____	Phone: _____
Primary Care: _____	Phone: _____
Preferred Hospital: _____	Phone: _____
Pharmacy: _____	Phone: _____
Parent/Guardian Signature: _____	Date: _____
Epilepsy Provider Signature: _____	Date: _____