Oconomowoc Area School
Health Services Office
Phone: 262-560-2104
Fax: 262-560-2106

SEIZURE ACTION PLAN

Student's Name:_____ Date of Birth:_____
School Attending:_____ Grade:_____ School Year:_____
Practitioner:_____ Practitioner Phone:_____

☐ Seizures are no longer an issue for my child. (Please sign and return Care Plan)

Significant medical history:_____

SEIZURE INFORMATION: When was your child diagnosed with seizures or epilepsy?_____

Seizure Type	*Length*	*Frequency*	*Description*

Date of last Seizure_____

Seizure triggers or warning signs:_____

Student's reaction to seizure:_____

BASIC FIRST AID: CARE & COMFORT: *(Please describe basic first aid procedures)*

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

Basic Seizure First Aid:
- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol: *(Check all that apply and clarify below)*
☐ Contact school nurse
☐ Call 911
☐ Notify parent or emergency contact
☐ Administer emergency medications as indicated below
☐ Other_____

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication

Practitioner Signature:_____ **Date:**_____

On the last day of school how should medications be returned? ☐**Sent home with Student** ☐**Parent/Guardian Pick-Up**

- I hereby give permission to OASD's trained staff to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's practitioner with any concerns regarding medication administration. I agree to hold the Oconomowoc Area School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- I allow the named practitioner (office) to send by electronic transmission this form to the Oconomowoc Area School District for the purpose of continuing health care at school.
- I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

Parent/Guardian Signature:_____ **Date:**_____