

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): _____

Name of Med/Rx: _____

How much to give (dose): _____

How to give: _____

If seizure (cluster, # or length): _____

Name of Med/Rx: _____

How much to give (dose): _____

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: _____