Seizure Management Plan

Oak Creek-Franklin Joint School District, Oak Creek, WI

Student Name :______________________________ Birthdate: ____________________

School: ______________________________ Sex: ☐ M ☐ F

Emergency Contact #1: ____________________ Home #:__________ Work #:__________

Emergency Contact #2: ____________________ Home #:__________ Work #:__________

Health Care Provider: __________________ Phone #: ________ Preferred Hospital: __________

Daily Medications: ________________________ Warning Signs: ☐ Yes ☐ No What? __________

Diastat: ☐ Yes ☐ No Location to be kept: ________________ Vagus Nerve Stimulator (VNS) ☐ Yes ☐ No

Versed: ☐ Yes ☐ No Location to be kept: ________________

Nayzilam ☐ Yes ☐ No Location to be kept: ________________

Observations/Symptoms

- ☐ Blank Stare/daydreaming
- ☐ Not oriented to time or place
- ☐ Chewing movements
- ☐ Rapid blinking/eye movements
- ☐ Muscle jerking
- ☐ Loss of muscle tone
- ☐ Sudden Collapse

Other ______________________

____

____

____

Action Steps

Assist student to lie down
Gently turn student onto his/her side
Protect student's head from injury (use pillow or clothing)
Do not place anything in student's mouth
Remove nearby objects to prevent injury
Allow rest after seizure. May stay in school
Notify the student's parent
If ordered administer medication if seizure longer than _______ minutes
If ordered access VNS as indicated
Document appropriately

Call 9-1-1 if:

The student has no history of previous seizure
The seizure occurs in water
The seizure lasts longer than ________ minutes
There is a series of seizures
The student is injured during the seizure
Emergency medication is administered

I agree to the above action plan and allow this information to be shared confidentially as determined by the school principal.

______________________________ ______________________________
Signature (Parent/Guardian) Date

______________________________ ______________________________
Physician's Signature Date

______________________________ ______________________________
Physician Address Phone/Fax #