

Needham Public Schools
Seizure Action Plan

Student Name _____ D.O.B. _____
Teacher _____

Paste
Photo
Here

EMERGENCY CONTACTS

Name Relationship Home # Work # Cell #

1. _____
2. _____
3. _____

Type of seizure:

What does the seizure look like and how long does it usually last?

Does your student need any special restrictions/ adaptations/protective equipment at school? _____ No _____ Yes (explain)

Is student allowed to participate in physical education and other activities? No ___ Yes

MEDICATIONS TAKEN

- 1.
- 2.
- 3.

List medication needed at school (name, dosage/route, and frequency)

IF GENERALIZED SEIZURE OCCURS:

1. If falling, assist student to floor, turn to side.
2. Loosen clothing at neck and waist; protect head from injury.
3. Have another adult remove other students from the immediate area.
4. TIME THE SEIZURE.
5. Allow seizure to run its course; DO NOT restrain or insert anything into the student's mouth. Do not try to stop purposeless behavior.
7. During a general or grand mal seizure, expect to see pale or bluish discoloration of the skin or lips. Expect to hear noisy breathing.
8. Call the nurse at extension:

If symptoms are: _____

Give _____ Call 9-1-1
(medication/dose/route)

Physician Signature _____

Name _____ Date _____

Phone _____

I hereby give my permission for exchange of confidential information contained in the record of my child between the nurse and physician and my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

Parent/Guardian Signature: _____ Date: _____

Approved by School Nurse

School Nurse Signature: _____ Date: _____