Whitehall-Coplay School District

Seizure Action Plan

Student: ______________________________________ Date: __________
Teacher/Classroom: ____________________________ Bus: ______________
Allergies: ______________________________________

Seizure type: ______________________________________
Description of signs and symptoms during seizure: __________________________
_____________________________________________________________________
_____________________________________________________________________

Daily Medications: ______________________________________
_____________________________________________________________________
_____________________________________________________________________

(medications/dosages)

Treatment

DO NOT PUT ANYTHING IN THE MOUTH
* Cushion head, remove glasses *Loosen tight clothing
* Turn on side and keep airway clear *Note time seizure starts and length of time it lasts
* Don’t hold down

Medications: ____________________________
(medication/dose/route)

Call -911 if:
Seizure does not stop within ________ minutes
Child does not start to wake up within ________ minutes after seizure is over

Following seizure: (please check)
___ Child should rest in nurse’s office
___ Child may return to class
___ Parent/guardian should be notified

Emergency Calls

1. Parent/guardian: ______________________________________

____________________________________________________________________

2. Additional emergency Contacts: ____________________________

3. Physician:
   Parent/Guardian Signature: ____________________________ Date:
   Physician Signature: ____________________________ Date:
   School Nurse: ____________________________ Date: __________
School personnel informed: copies are distributed on a need to know basis:

- English teacher
- Math teacher
- Science teacher
- Social Studies teacher
- PE
- Art
- Library
- Music
- Cafeteria
- Guidance
- Office Personnel

Care Plans are updated yearly and/or throughout the school year as needed.