A Seizure Action Plan (SAP) is a document that provides detailed health and medical information about a student and his/her epilepsy or seizure disorder. The SAP provides guidelines as to how to respond when a student is experiencing a seizure. This document will include input from the student’s guardian, physician, and/or neurology specialist.

Who uses it?
Every individual who interacts with a student who has a seizure disorder will benefit from this information. Specifically, school teachers, school nurses, coaches, and other individuals with supervisory roles should receive and review the SAP.

Where is it kept?
Typically, school nurses serve as the “gatekeeper” of the SAP. It is advisable for a school nurse to have the SAP in the student’s file, and the classroom teacher(s) should have a copy. Parents and physicians should keep a copy as well.

Why is it necessary?
When your child has been diagnosed with epilepsy, you quickly learn when a seizure is a medical emergency. The information in this SAP helps others to recognize your child’s seizures and determine when it’s an emergency. This prevents unnecessary 911 calls.

Who will benefit?
Everyone benefits from a SAP. Students are more likely to receive an appropriate response, school teachers and school nurses have the necessary information to respond and provide first aid, and parents are more at ease knowing that a written plan is in place.

Is there a cost involved?
No, a SAP is free provided that the student has access to, and visits, a physician treating their seizure disorder. The only cost involved is related to the time it takes to write and read the document.

How often is the SAP updated?
It will depend on the needs of each student and changes in his/her medical condition. Most students will have the SAP for the entire school year and maybe as long as they attend a given school. Students with more complex conditions may have their plan updated more frequently by their physician or medical specialist.
THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Student’s Name: _______________________________ Date of Birth: __________________

Parent/Guardian: _______________________________ Phone: _____________ Cell: _____________

Treating Physician: _______________________________ Hospital: _____________ Phone: _____________

Significant medical history: _______________________________

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SEIZURE INFORMATION:

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
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Seizure triggers or warning signs: ____________________________________________

Student’s reaction to seizure: ______________________________________________

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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

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EMERGENCY RESPONSE:

A “seizure emergency” for this student is defined as:

Seizure Emergency Protocol: (Check all that apply and clarify below)

☐ Contact school nurse at _______________________________

☐ Call 911 for transport to _______________________________

☐ Notify parent or emergency contact _______________________________

☐ Notify doctor _______________________________

☐ Administer emergency medications as indicated below _______________________________

☐ Other _______________________________

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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 difficulty breathing _______________________________

☐ Student has a seizure in water _______________________________

---

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

<table>
<thead>
<tr>
<th>Daily Medication</th>
<th>Dosage &amp; Time of Day Given</th>
<th>Common Side Effects &amp; Special Instructions</th>
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Emergency/Rescue Medication: ________________________________________________

Does student have a Vagus Nerve Stimulator (VNS)? YES NO

If YES, Describe magnet use ______________________________________________

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SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: (regarding school activities, sports, trips, etc.)

Physician Signature: _______________________________ Date: __________________

Parent Signature: _______________________________ Date: __________________