**Seizure Action Plan Form**  
*For Educational Institutions*

**Student Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name:** |  | | |
| **Date of Birth:** |  | **Grade/Class:** |  |
| **School Name:** |  | | |
| **Parent/Guardian Name(s):** |  | **Primary Contact Number:** |  |
| **Secondary Contact Number:** |  | **Doctor/Neurologist Name:** |  |
| **Doctor’s Contact Number:** | |  | |

**Seizure History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type(s) of Seizure(s):** | ☐ Generalized Tonic-Clonic | ☐ Absence | ☐ Myoclonic |
| ☐ Atonic | ☐ Focal | ☐ Other: |
| **Date of Diagnosis:** |  | **Typical Duration of Seizures:** |  |
| **Frequency of Seizures:** |  | **Last Seizure Date:** |  |

**Seizure Description**

|  |  |  |  |
| --- | --- | --- | --- |
| Please describe what typically happens during your child’s seizure: | | | |
|  | | | |
|  | | | |
| **Known Trigger(s):** | ☐ Lack of sleep | ☐ Stress | ☐ Flashing lights |
| ☐ Illness | ☐ Missed medication | ☐ Other: |

**First Aid Response Instructions**

|  |  |  |  |
| --- | --- | --- | --- |
| **During a Seizure:** | ☐ Stay calm and stay with the student | ☐ Keep them safe from injury (move harmful objects) | ☐ Do not restrain movement unless in danger |
| ☐ Do not put anything in their mouth | ☐ Time the seizure | ☐ Turn the student on their side after seizure (if applicable) |
|  | ☐ Administer emergency medication (if prescribed — see below) | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **After a Seizure:** | ☐ Allow the student to rest | ☐ Notify parent/guardian | ☐ Document the seizure |
| ☐ Seek medical help if: | | |
| Seizure lasts more than \_\_\_ minutes | Student does not regain consciousness | Another seizure starts immediately |
| Student is injured |  |  |

**Emergency Medication**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Name:** |  | **Dosage & Route:** |  |
| **Instructions for Use:** |  | | |
| **Medication Location at School:** |  | | |
| **Staff Trained to Administer Medication** |  | | |

**Additional Instructions or Notes**

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**Consent and Authorization**

I give permission for school personnel to follow this plan, contact the healthcare provider if necessary, and administer the above medication if needed. I understand that this form will be shared with relevant staff for the safety of my child.

**Parent/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_  
**Physician Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_