Bryan ISD Nursing Services

Seizure Action Plan

Student Name:_____ **DOB:** _____ **ID Number:** _____

Parent/Guardian (*Padre/Tutor)*_____ Phone (*Teléfono)* _____

Emergency Contact (*Contacto de Emergencia*) _____ Phone (*Teléfono)* _____

Parent/Guardian Consent to Administer Medications/Autorización de los padres/tutores para la administración de medicamentos

I, the parent/guardian of the named student, request that this action plan be used to guide care for my child and consent to the administration of medications as prescribed by the physician. I agree to: (*Yo, el padre/tutor del estudiante nombrado, pido que este plan de acción sea utilizado para guiar el cuidado de mi hijo y doy mi autorización para la administración de medicamentos según lo recetado por el médico. Estoy de acuerdo con:)*

1. Provide necessary supplies, equipment, and medications. *(Proporcionar los materiales, el equipo y los medicamentos necesarios.)*
2. Notify the school nurse of any changes in the student 's health status and complete a new consent form if any changes in the orders are made from the physician. (*Informar a la enfermera de la escuela de cualquier cambio en el estado de salud del estudiante y completaré un nuevo formulario de consentimiento si hay cambios en las órdenes del médico.)*
3. Authorize the school nurse to communicate verbally and in writing with the student 's health care provider about this condition and corresponding orders/action plans. *(Autorizar a la enfermera de la escuela para que se comunique verbalmente y por escrito con el proveedor de atención médica del estudiante sobre esta condición y las órdenes o planes de acción correspondientes.)*
4. School staff interacting directly with my child may be informed about his/her condition and corresponding medical needs while at school. *(El personal de la escuela que interactúa directamente con mi hijo puede ser informado sobre su condición y sus necesidades médicas correspondientes mientras está en la escuela.)*

_____ _____

Parent/Guardian Signature *(Firma del Padre/Tutor)* **Date *(Fecha)***

**To Be Completed by Physician*

Seizure Type	Length & Frequency	Description	Triggers or Warning Signs

Emergency Response

Seizure Emergency Protocol (check all that apply)

- ☐ **Contact school nurse at** _____
- ☐ **Call 911 for transport to hospital**
- ☐ **Notify parent/guardian or emergency contact**
- ☐ **Administer emergency medications as indicated below**
- ☐ **Notify doctor**
- ☐ **Other:** _____

Basic Seizure First Aid

- **Stay calm & begin timing the seizure**
- **Keep student safe: remove harmful objects & protect their head**
- **Do not restrain**
- **Do not put anything in their mouth**
- **Turn student on side**
- **Keep airway open and monitor breathing**
- **Stay with student until they recover and are fully conscious**
- **Record Seizure in log if applicable**

Seizure Emergencies - When to Call 911

- **Seizure lasting > 5 minutes**
- **Student has repeated seizures without regaining consciousness**
- **Student is injured, has diabetes and/or is pregnant**
- **Student has a first-time seizure**
- **Student has breathing difficulties**
- **Student has a seizure in water**

Emergency Medication Name *(provided by parent/guardian)*	Dose	When to Use *(Cluster, # or length)*

Does the student have a Vagus Nerve Stimulator? ☐ Yes ☐ No

If YES, describe magnet use instructions: _____

Does the student need to leave the classroom after a seizure? ☐ Yes ☐ No

If YES, when can the student return to class and/or resume usual activity?_____

Is the student able to manage and understand their seizures? ☐ Yes ☐ No

Other Information

Daily Seizure Medication Name	Dose	Time to be Given	Common Side Effects	Special Instructions

Important medical history: _____

Epilepsy Surgery (*type, date, side effects*): _____ **Allergies:** _____

Diet Therapy: ☐ Ketogenic ☐ Low-Glycemic ☐ Modified Atkins ☐ Other _____ **☐ N/A**

Special Considerations and/or Restrictions (*school activities, sports, trips, etc.*): _____

Physician Name (*printed*): _____ **Phone number:** _____

Physician Signature: _____ **Date:** _____

This plan is valid for current school year including summer school unless changes are made*

Rev 1/10/25