

YOUTH Seizure Action Plan & Parent Questionnaire

CONTACT INFORMATION:

Nurse's Name: _____ Phone: _____
 Student's Name: _____ School Year: _____
 School: _____ Grade: _____ Classroom: _____
 Parent/Guardian Name: _____ Tel. (H): _____ (W): _____ (C): _____
 Other Emergency Contact: _____ Tel. (H): _____ (W): _____ (C): _____
 Child's Neurologist: _____ Tel: _____ Location: _____
 Child's Primary Care Dr.: _____ Tel: _____ Location: _____

Significant medical history or conditions: _____

SEIZURE INFORMATION:

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Response after a seizure: _____

TREATMENT PROTOCOL: (include daily and emergency medications)

Emergency Med? <input checked="" type="checkbox"/>	Medication	Dosage & Time of Day Given	Route of Administration	Common Side Effects & Special Instructions

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

If YES, describe magnet use _____

BASIC FIRST AID: CARE & COMFORT:

Please describe basic first aid procedures: _____

Does person need to leave the room/area after a seizure? YES NO

If YES, describe process for returning: _____

EMERGENCY RESPONSE:

A "seizure emergency" for this person is defined as: _____

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

- Call 911 for transport to _____
- Notify parent or emergency contact
- Notify doctor
- Administer emergency medications as indicated below

Basic seizure first aid:

- Stay calm & track time
- Keep person safe
- Do not restrain
- Do not put anything in mouth
- Stay with person until fully conscious
- Record seizure in log

For tonic-clonic (grand mal) seizure:

- Protect head
- Keep airway open/watch breathing
- Turn person on side

A seizure is considered an emergency when:

- A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- There are repeated seizures without regaining consciousness
- It's a first-time seizure
- The person is injured or has diabetes
- The person has breathing difficulties
- The seizure is in water

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Other _____

SEIZURE INFORMATION:

1. When was your child diagnosed with epilepsy? _____
2. Will your child need to leave the classroom after a seizure? YES NO
If YES, describe best process for returning your child to classroom: _____
3. How often does your child have a seizure? _____
4. When was your child's last seizure? _____
5. Has there been any recent change in your child's seizure patterns? YES NO
If YES, please explain: _____
6. How do other illnesses affect your child's seizure control? _____
7. What medication(s) will your child need to take during school hours? _____
8. Should any of these medications be administered in a special way? YES NO
If YES, please explain: _____
9. Should any particular reaction be watched for? YES NO
If YES, please explain: _____
10. What should be done when your child misses a dose? _____
11. Should the school have backup medication available to give your child for missed dose? YES NO
12. Do you wish to be called before backup medication is given for a missed dose?

SPECIAL CONSIDERATIONS & PRECAUTIONS

Check any special considerations related to your child's epilepsy while at school. *(Check appropriate boxes and describe the impact of your child's seizures or treatment regimen)*

- | | |
|--|---|
| <input type="checkbox"/> General health: | <input type="checkbox"/> Physical education (gym)/sports: |
| <input type="checkbox"/> Physical functioning: | <input type="checkbox"/> Recess: |
| <input type="checkbox"/> Learning: | <input type="checkbox"/> Field trips: |
| <input type="checkbox"/> Behavior: | <input type="checkbox"/> Bus transportation: |
| <input type="checkbox"/> Mood/coping: | |
| <input type="checkbox"/> Other: _____ | |

GENERAL COMMUNICATION ISSUES

What is the best way for us to communicate about your child's seizure(s)?: _____

Does school personnel have permission to contact your child's physician? YES NO

Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent Signature: _____ Date: _____ Dates Updated _____, _____

Physician Signature: _____ Date: _____