Campus Nurse will attach Student Photo

Transportation
□ Car Rider □ Walker
□ Bus #_____
□ Other:_____
_____

Waller Independent School District

Seizure Action Plan

Student's Name	Date of Birth	GRADE
Parent/Guardian	Phone	Cell
Other Emergency contact	Phone	Cell
Significant Medical History:		

Seizure Description (Check all that apply)
□ Convulsions □ Involuntary rhythmic movements □ Staring □ Unconsciousness □ Stiffening □ Facial tics

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:	**Student's response after a seizure:**

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:

Basic Seizure First Aid
- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:
- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

Name of Emergency Medication:
_____

Dosage:_____
Route: _____
Administer for seizures lasting for more than _____minutes.

Seizure Emergency Protocol
* Contact campus nurse at _____
* Administer emergency medications
* Call 911
* Notify parent or emergency contact
* Document Episode/Student Accident Report Filed
* Other: _____

A seizure is generally considered an Emergency when:
- Convulsive (tonic-clonic) seizures lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first time seizure
- Student has breathing difficulties
- Student has a seizure in water

Medication(s) to be Given During School Hours

Medication	Dosage	Time to be Given	Common Side Effects/Special Instructions

Does student have a **Vagus Nerve Stimulator**? □ Yes □ No If YES, Location GENERATOR_____ MAGNET_____

VAGUS NERVE STIMULATION (VNS):
□ Swipe magnet at seizure onset.
□ Swipe for report of aura
□ Repeat swipe _____times every _____minutes. If seizure last 5 minutes, CALL 911 and implement Emergency Response indicated above.
□ Other:_____

KEEP MAGNET 10" AWAY FROM CREDIT CARDS, TELEVSION, CELL PHONES, COMPUTERS, MICROWAVES, WATCHES AND OTHER MAGNETS. THE MAGNET CAN BREAK IF DROPPED.
USE THE MAGNET BY MOVING OR PASSING THE MAGNET OVER THE GENERATOR FOR APPROXIMATELY 1 SECOND.
THE STUDENT WILL RECEIVE ONE MINUTE OF STIMULATION AFTER EACH MAGNET SWIPE.

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

□ **I AGREE** with the recommendations of my child's HCP and authorize Waller ISD staff to deliver treatment as outlined above.
□ **I DO NOT** approve of the standardized procedure(s) and, therefore have attached my alternate written recommendations.
I give permission for my child's HCP to communicate with appropriate Waller ISD employees for the current school year.

Physician Signature:	**Printed Name:**	**Phone:**	**Date:**
Parent Signature:	**Printed Name:**	**Phone:**	**Date:**

ADDENDUM to Action Plan

NURSE USE ONLY:

☐ Transportation Notified: Date Faxed _____

☐ Bus Driver Notified

☐ Added to Medical Alerts

☐ Self-Carry

☐ Diet Modification: Date Faxed _____

☐ RTI ☐ 504 ☐ ARD Committee Notified: Date _____

In addition: A full IHP needed for a 504 or an ARD

	Field Trips	Student will be grouped with a trained staff member.
	Before or After School Activities (i.e. Safety Patrol, Clubs, Sports)	Nurse and Parent will discuss a plan for their child.
	Emergency Evacuation of School	Nurse will bring medication/supplies out of building and will attend to student as needed.

◊ TRAINED STAFF MEMBERS ◊ (To be completed by campus personnel)	
Teacher's Name:	**Date:**
Teacher's Name:	**Date:**
Administrator's Name:	**Date:**
Office Staff's Name:	**Date:**
Cafeteria Staff's Name:	**Date:**
Bus Driver's Name:	**Date:**
Other Name:	**Date:**
Other Name:	**Date:**
Other Name:	**Date:**

OTHER COMMENTS:

_____

_____

_____

_____

_____

Nurse Signature: _____ Date: _____