CHERRY HILL PUBLIC SCHOOLS
SEIZURE ACTION PLAN
Adapted from Epilepsy Foundation

STUDENT INFORMATION:

Student Name: ☐ Male ☐ Female	Date of Birth: Grade:
School Name:	School Year: 20_____ to 20 _____
Parent/Guardian:	Phone number:
Emergency Contact/Relationship:	Phone number

SEIZURE INFORMATION:

Seizure Type	How Long it Lasts	How Often	What Happens

PROTOCOL FOR SEIZURE DURING SCHOOL: (check all that apply)

☐ First aid - **STAY. SAFE. SIDE**	☐ Contact school nurse at:
☐ Give rescue medication according to the plan below (nurse only)	☐ Call 911 for transport to:
☐ Notify parent/emergency contact	☐ Other:

FIRST AID FOR ANY SEIZURE:

☐ STAY calm, begin **TIMING** seizure	☐ SAFE- Keep airway clear, do **NOT** put objects in the mouth.
☐ SAFE- Remove harmful objects, don't restrain, protect head	☐ SIDE - Turn on the side if not awake
☐ SAFE- Gently lower to the floor when possible	☐ STAY until recovered from the seizure

CALL 911 WHEN:

☐ Seizure with loss of consciousness and/or not responding to rescue medication if available
☐ Repeated seizures lasting longer than 10 minutes, no recovery between them, not responding to rescue medication if available
☐ Change in seizure type, number or pattern
☐ Person does not return to usual behavior (i.e. confused for a long period)
☐ Difficulty breathing after a seizure
☐ Serious injury occurs or suspected, seizure in water
☐ Other:

EMERGENCY MEDICATION :

If seizure (cluster, number or length):		
Medication:	Dose:	Route:

INSTRUCTIONS FOR POST SEIZURE CARE:

DAILY SEIZURE MEDICATIONS:

Medication	Dose	Frequency

SPECIAL INSTRUCTIONS:

VNS:
Other:

OTHER INFORMATION:

Triggers:
Important Medical History:
Allergies:
Epilepsy Surgery (type, date, side effects):
Device: ☐ VNS ☐ RNS ☐ DBS Date implanted:
Diet Therapy: ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe)
Special Instructions:

HEALTH CARE CONTACTS:

Epilepsy Provider (print):	Phone:
Primary Care (print):	Phone:
Preferred Hospital (print)	Phone:

SIGNATURES:

I consent to the release of the information contained in this Seizure Action Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I give permission to the school nurse or another qualified healthcare professional to contact my child's healthcare provider. We understand that the Cherry Hill Public School District shall incur no liability as a result of any injury arising from the above Seizure Action Plan. We further acknowledge that we understand that any person who acts in good faith in accordance with the requirements of law shall be immune from any civil or criminal liability arising from actions performed pursuant to this request.

Parent/Guardian Name:	Signature:	Date:
Provider Name: (STAMP)	Signature:	Date: