Carla Wilfert, RN, BSN
District Nurse Coordinator
Health Services Department

(520) 209-8081
cwilfert@cfsd16.org
www.cfsd16.org

SEIZURE ACTION PLAN

*School:*_____*Year*_____

Student name:	Date of Birth:	Grade:

Type of Seizure: _____Triggers or warning signs: _____
DOES STUDENT HAVE A ***VAGUS NERVE STIMULATOR (VNS)?*** YES NO
DOES STUDENT NEED TO LEAVE CLASSROOM AFTER SEIZURE? YES NO _____

DURING the Seizure:

- Note time seizure begins and ends.
- Stay with the student.
- Lay the student on their side.
- Do NOT put anything in the student's mouth.
- Do NOT restrain the student.
- Put something soft under their head for protection.
- Keep student safe: remove sharp objects, clear area of chairs, tables, etc.
- Loosen any tight clothing.
- Call for the School Health Assistant or School Nurse.
- Notify Parent/Guardian NAME: _____PHONE: _____
- Contact School Nurse at: _____

ADMINISTER EMERGENCY MEDICATION: _____

AFTER the Seizure:

- Stay with the student until they are awake and alert.
- Provide comfort and reassurance.
- Allow the student to return to normal activities if allowed by the parent/guardian or follow parent/guardian instruction.

CALL 911 When:

- Convulsive (tonic-clonic) seizure 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.
- Indicated by Parent/Guardian.

**This is confidential information. Under FERPA law, each staff member that has this information has the responsibility to prevent inadvertent disclosure and is to store protected health information in a secure location. Please contact the school nurse if you have any questions. *This Individualized Health Plan provides for routine accommodations that the Catalina Foothills School District (CFSD) makes available to any student who needs such routine accommodations. This IHP is separate and does not require a 504 plan or Individualized Education Plan (IEP) to accompany it*

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature:_____ Date: _____

Revised 9/20019