WESTWOOD PUBLIC SCHOOLS
Westwood, Massachusetts

SEIZURE ACTION PLAN

September _____ to June _____

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____ Cell: _____

Treating Physician: _____ Phone: _____

Significant Medical History

_____

Seizure Information

Seizure Type	Average length	Description

Average frequency: _____

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

_____

Basic First Aid: Care & Comfort

Please describe basic first aid procedures: _____

_____

Does the student need to leave the classroom after a seizure? _____ If yes, please describe process for returning to classroom: _____

_____

Emergency Response

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

_____

A seizure is generally considered an emergency when:

- A convulsive (tonic-clonic) seiure lasts longer than five minutes.
- Student has repeated seizures without regaining consciousness.
- Student has a first-time seizure.
- Student is injured or has diabetes.
- Student has breathing difficulties.

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Seizure Emergency Protocol: Please check all that apply and clarify below.

___ Contact school nurse at _____
___ Call 911 for transport to _____
___ Notify parent or emergency contact.
___ Notify doctor.
___ Administer emergency medications as indicated below.
___ Other.

Treatment Protocol During School Hours

Daily Medication	Dosage and Time of Day Given	Common Side Effects and Special Instructions
Emergency/Rescue Medication		

Does student have a Vagus Nerve Stimulator? _____ If yes, describe magnet use: _____

_____

Special Accommodations and Safety Precautions
Regarding school activities, sports, trips, etc.

_____

_____

_____

1. I have read and reviewed the Health Care Plan formulated by my child's physician. I give permission for the school nurse or trained designee to follow the Plan. I understand that the emergency plan will be sent and followed on all field trips.
2. I give permission for this information to be shared with school staff as needed to my child's safety.
3. I will contact the Food Service Department at 781-326-7500, x.4350 to discuss any dietary needs my child may have.

I give the licensed school nurse permission to consult (both verbally and in writing) with the above-named student's physician regarding any questions that arise about the medical condition and/or medications/treatments/procedures being used to treat the condition. ___ Yes ___ No

Physician's signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____