AUSTIN Independent School District | Health Services and Nursing

School Name:_____

Seizure Action Plan

Your school nurse will use the following information to plan for safe care of your child should a seizure occur at school. Parents/guardians are notified and EMS (911) will be called if a student has difficulty breathing, a seizure lasting longer than 5 minutes, if more than one seizure occurs or if seizure occurs on the school bus.

Student Name: _____ **Birth Date:** _____ **Student ID#:** _____ **Grade:** _____

Parent/Guardian: _____ **Phone number**: _____

Emergency Contact: _____ **Phone number**: _____

Physician treating seizures: _____ **Office Phone number:** _____

Seizure Information			
Seizure Type	**How long seizure lasts**	**How often**	**What happens during seizure**

Seizure triggers or warning signs: _____

Student's reaction to seizure: _____

When was the last known seizure? _____ Medications given at home _____

Treatment Protocol During School Hours (Include Daily and Emergency Medications)		
Emergency Medication	**Dosage & Time of Day Given**	**Common Side Effects and Special Instructions**

If Diastat is Ordered, has the student received this dose before? YES _____ NO ____

If Student has not received this dose before, EMS will be called after Diastat is administered.

Call EMS every time Diastat is administered? YES_____NO_____

When a nurse is on campus, the student will be monitored under direct observation for seizure activity, breathing and color changes, until the student is stable.

EMS will be called if:

- Student Health Services is **NOT** on campus and Diastat was administered by trained AISD staff
- One dose of Diastat does not stop the seizure in _____ minutes
- Another seizure begins within _____ minutes after one ends
- Parent is unable to pick-up student within 30 minutes after Diastat administration
- Other Instructions: _____

Does Student have a Vagus Nerve Stimulator? YES ____ NO ____ If YES, describe magnet use _____

Describe any special considerations and precautions (regarding transportation to school, sports, field trips, etc.) _

_____

Authorization for Release of Medical Information

I hereby authorize _____ to furnish medical information regarding
(Clinic/Provider)

my child _____ to the School Nurse at _____.
Student's name **School**

I give permission for the School Nurse to communicate with my child's doctor concerning their medical condition.

_____ _____ _____
Parent/guardian's Signature **Print name** **Date**

Physician's Signature: _____ **Date:** _____