Williamson County Schools
Seizure Action Plan for School

(This form must be signed by the Physician)

Student Name_____ Date of Birth_____

School_____ Grade_____ School Year_____

SEIZURE TYPE:_____ Date or Age of Diagnosis_____

Triggers or Warning Signs (list) _____

_____

Date, Description, Treatment after last seizure_____

_____

Other Significant Medical History_____

EMERGENCY ACTION PLAN

1. Contact School Nurse at _____.
2. Note start time of seizure.
3. Administer emergency medications below - trained staff only.
4. CALL 911 if anti-seizure meds are given or No nurse available.
5. Re-orient and reassure student.
6. Notify parent or emergency contact.

Basic Seizure First Aid:

- Stay calm and send for help
- Direct other students away from area
- Stay with child and protect from injury
- Do NOT restrain or put anything in mouth
- Gently support head
- Keep airway open and watch breathing
- Place on floor and turn onto side

PHYSICIAN'S ORDER – EMERGENCY MEDICATIONS

Name of Medication	Dosage and Route to be Given	When to Administer at School

***Diazepam may not to be used more than 5 times a month and/or more than once in 5 days.**

Does student have a **Vagus Nerve Stimulator**? ☐ No ☐ Yes, location and magnet use:_____

Special Instructions_____

Physician's Signature_____ **Date**_____

Physician's Name (Print)_____ **Phone**_____

PARENT/GUARDIAN'S AUTHORIZATION

I give permission for the medicine/treatment listed to be administered in school by the nurse or other trained personnel. I consent to communication between the school nurse and prescribing health care provider or clinic to discuss administration and use of this medication/treatment. I agree that the Williamson County Board of Education shall incur no liability and be held harmless against any claims of injury related to the administration of such medication/treatment.

Parent/Guardian's Signature_____ **Date**

Parent/Guardian's Name (Print)_____ **Phone**_____

Emergency Contact_____ **Phone**_____

Medication received by _____ *Date* _____ *Exp. Date*_____

Exp. Check	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July
Nurse Initial												