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 keep safe
- Do not restrain or put anything in mouth
- Protect head
- Keep airway open and watch breathing
- Turn onto side if possible

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 in the school setting.

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 (Required)

I give permission for the medication(s) 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 disease management and administration of the medication. The undersigned parent/guardian hereby agrees to exempt and release the school district and its directors, officers, employees, volunteers, and agents from any and all liability, claims, demands, or actions whatsoever arising out of any damage, loss, or injury that my student or I/we might sustain or which they now have or may hereafter have arising out of the administration of this medication.

Parent/Guardian's Signature _____ **Date** _____

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

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