OKLAHOMA State Department of Health

OKLAHOMA Education

Oklahoma Seizure Safe Schools Seizure Action Plan

Date: ____________________ **(Valid for one year from this date)**

Name: ____ **DOB:** ___________________

Address: ____

City: ________________________________ **State:** ________________ **Zip:** _____________

Primary Phone: ____

Emergency Contact / Relationship: ____

Phone: ____

Seizure Information

Seizure Type	Brief Description

How to respond to a seizure (Check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact
- ☐ Call 911
- ☐ Other ____________________________

First Aid for any seizure

- ☐ **STAY** Calm, keep calm, begin timing the seizure.
- ☐ Keep me **SAFE** – Remove harmful objects, don't restrain, protect head.
- ☐ **SIDE** – Turn on side if not awake, keep airway clear, don't put objects in mouth.
- ☐ **STAY** until recovered from seizure.
- ☐ Swipe magnet for VNS.
- ☐ Write down what happened: ________________________________
- ☐ Other: ________________________________

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes and not responding to rescue medication.
- ☐ Repeated seizures longer than 10 minutes. No recovery between them. Not responding to rescue medication.
- ☐ Difficulty breathing after seizure.
- ☐ Serious injury occurs or suspected. Seizure in water.

When **RESCUE THERAPY** may be needed:

WHEN AND WHAT TO DO

If seizure (Cluster, # or length): ____
Name of Med/Rx: _____________________________ Dose: _________________

If seizure (Cluster, # or length): ____
Name of Med/Rx: _____________________________ Dose: _________________

If seizure (Cluster, # or length): ____
Name of Med/Rx: _____________________________ Dose: _________________

After Seizure Care

Can the student return to the classroom after seizure Yes No

Can the student return to normal activities once returned to baseline Yes No

Daily Seizure Medications

Medication	Dose	Amount of Tab / Liquid	How Taken (Time of each dose and how much)

Other information

Triggers: ____
☐ **None**

Allergies: ____
☐ **None**

Implanted Device: _____ VNS _____ RNS _____ DBS Date Implanted: ______________________________

Diet Therapy: _____ Ketogenic _____ Low Glycemic _____ Modified Atkins _____ Other: ________________

Special instructions: ____

Parent or
Legal Guardian Signature: _____________________________________ Date: _____/ _____/_____

Provider Signature: ____ Date: _____/ _____/ _____

Reviewed by School Staff: _____________________________________ Date: _____/_____/_____

____ Date: ____/_____/______