School District of Indian River County

SEIZURE ACTION PLAN (SAP)

Must completed by Health care Provider

Students Name Date of Birth

_____

Parent/guardian Name Phone Cell

_____

Other Emergency Contact Phone Cell

_____

Treating Physician Phone

_____

Significant Medical History

_____

SEIZURE INFORMATION

Seizure Type	Length	Frequency	Description

Seizure Triggers or warning signs: _____

Response after a Seizure: _____

BASIC SEIZURE FIRST AID

- Stay calm & track time
- Keep Student Safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Protect Head
- Keep airway open/watch breathing
- Turn student on their side

SEIZURE EMERGENCY PROTOCOL

A seizure emergency for this child is defined as: _____

_____

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Must completed by Health care Provider

Call 911 for the following (check all that apply):

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water
- ☐ Person does not return to usual behavior (i.e., confused for a long period)

- Notify parent or emergency contact
- Administer emergency medications as indicated below
- Other: _____

TREATMENT PROTOCOL (Include Daily and emergency medications)

Medication Name	Dosage	Frequency	Route

Does student have a Vagus Nerve Stimulator? ___Yes ___No

Special considerations and Precautions (Please describe): _____

Healthcare Provider signature: _____ Date: _____

Parent/guardian Signature: _____ Date: _____