Seizure Action Plan

Place Child's

Picture Here

Date:_____

Student's Name: _____ DOB:_____

Center/Classroom:_____

SIGNS/SYMPTOMS:

- ▫
- ▫
- ▫
- ▫
- ▫
- ▫
- ▫
- ▫

INTERVENTIONS: [ie. "IF (blank) THEN (blank)*, make sure to include medications or other treatments, specify IF or WHEN 911 should be called]

- ▫ If has temperature of _____ degrees Fahrenheit axillary or higher then administer fever reducing medication per instruction on the Authorization to Administer Prescription and Non-Prescription Medication form and call parent to pick-up.
- ▫ If exhibiting signs/symptoms of having a seizure listed above then call 911 and then call parent/guardian.
- ▫
- ▫

DO NOT HESITATE TO CALL 911

OTHER PERTINENT INFORMATION:

WHO SHOULD BE NOTIFIED?

After following the above outlined interventions, CALL:

Primary Parent/Guardian:

Contact:_____

(First & Last Name)

OR

Secondary Parent/Guardian:

Contact: _____

(First & Last Name)

OR

Designated emergency contacts

Health Care Provider Signature:_____ Date:_____

Health Care Provider Printed Name _____

Parent/Guardian Signature:_____ Date:_____