HS0026
Rev. 7/22

SEIZURE ACTION PLAN

Health Services Department
Lincoln Public Schools • Lincoln, Nebraska

Student Name: _____ ID#: _____ Grade: _____

☐ **Please check here and sign if your student has not had a seizure in 3 years, and is not taking medications for seizure activity.**

Parent Signature: _____ Date: _____

STOP HERE if you checked this box. Return form to the Health Office.

HISTORY OF SEIZURES

First Seizure: _____

Surgical intervention if any: _____

Identify the specific signs and symptoms of your student's seizures:

❑ Temporary Confusion ❑ Loss of consciousness/awareness ❑ Other: _____
❑ Staring ❑ Uncontrolled movements of arms/legs

Average Length of Seizure: _____ How Often do the Seizures Occur?: _____

Identify triggers that may cause the seizure:

❑ Blinking lights ❑ Specific time of day or night ❑ Lack of sleep ❑ Foods
❑ Stress ❑ Menstrual cycle ❑ Other: _____
❑ Dehydration

LOCATION OF EMERGENCY MEDICATIONS/INTERVENTIONS:

❑ Health Office ❑ Self ❑ Other (describe): _____

EMERGENCY PLANS FOR SCHOOL STAFF

1. Emergency action is necessary when the student has the following signs and symptoms:
   a) seizure lasting longer than _____ minutes;
   b) or: _____
2. Please share information for a school evacuation, relocation or lock down situation. (ex. Parent will provide extra emergency medication to be kept in the classroom.

MEDICATIONS USED EVERY DAY				DOSE/ROUTE	TIMES/DAY
INTERVENTION				**FREQUENCY**	
VNS?	❑ Yes	❑ No	If yes, see below.		
Helmet?	❑ Yes	❑ No	If yes, see below.		

-LPS form HS0019 (Request to Provide Medications) must be completed for medications administered at school.
-LPS Form HS0037 (Parent/Guardian Request for Specialized Care Procedure) must be completed for VNS use.
-Health care provider orders are required for helmet use related to seizures and VNS use.

(OVER)

EMERGENCY MEDICATIONS	DOSE/ROUTE	TIMES/DAY

If your student will have Diastat at school, additional information will be requested by the school nurse.

CONTACT PARENT/GUARDIAN WHEN:

Comments/Special Instructions:

Name of medical provider: _____

Parent/Guardian name: _____

Best contact phone number: _____

Parent/Guardian signature: _____ Date: _____

This form is requested yearly if your child is affected by a seizure disorder.

- This information is important to keeping your student safe, and providing correct emergency response at school.
- It is a priority for us to have current emergency contact information for you.
- Written authorization from your student's licensed medical provider is required for medically necessary cares at school (if any needed, including medications, vagal nerve stimulator (VNS), or helmet). **New authorization is needed for each school year and/or when medical orders change**.
- In order for your student to participate in any swimming related activity, **parent/guardian must provide annual written order from the health care provider.**
- The school nurse may contact you or your student's licensed medical provider if additional information or clarification is needed for cares at school.
- Information will be shared as appropriate with other school and emergency personnel to benefit your student's safety and success.
- If you have questions, please contact the school nurse at your student's school.

OFFICE USE ONLY

DATE	ANNUAL REVIEW COMMENTS