YOUTH Seizure Action Plan & Parent Questionnaire

CONTACT INFORMATION:

Nurse's Name:_____ Phone:_____

Student's Name:_____ School Year:_____

School:_____ Grade:_____ Classroom:_____

Parent/Guardian Name:_____ Tel. (H):_____ (W):_____ (C):_____

Other Emergency Contact:_____ Tel. (H):_____ (W):_____ (C):_____

Child's Neurologist:_____ Tel:_____ Location:_____

Child's Primary Care Dr.:_____ Tel:_____ Location:_____

Significant medical history or conditions:

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:_____

Response after a seizure:_____

TREATMENT PROTOCOL: (include daily and emergency medications)

Emergency Med? ✓	*Medication*	*Dosage & Time of Day Given*	*Route of Administration*	*Common Side Effects & Special Instructions*

Does child have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, describe magnet use_____

BASIC FIRST AID: CARE & COMFORT:

Please describe basic first aid procedures: _____

_____

Does person need to leave the room/area after a seizure? YES NO

If YES, describe process for returning: _____

_____

EMERGENCY RESPONSE:

A "seizure emergency" for this person is defined as: _____

_____

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- ☐ **Call 911 for transport to** _____
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below

Basic seizure first aid:

- Stay calm & track time
- Keep person safe
- Do not restrain
- Do not put anything in mouth
- Stay with person until fully conscious
- Record seizure in log

For tonic-clonic (grand mal) seizure:

- Protect head
- Keep airway open/watch breathing
- Turn person on side

A seizure is considered an emergency when:

- A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- There are repeated seizures without regaining consciousness
- It's a first-time seizure
- The person is injured or has diabetes
- The person has breathing difficulties
- The seizure is in water

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☐ Other_____

SEIZURE INFORMATION:

1. When was your child diagnosed with epilepsy?_____
2. Will your child need to leave the classroom after a seizure? YES NO
   If YES, describe best process for returning your child to classroom:_____
3. How often does your child have a seizure?_____
4. When was your child's last seizure?_____
5. Has there been any recent change in your child's seizure patterns? YES NO
   If YES, please explain:_____
6. How do other illnesses affect your child's seizure control?_____
7. What medication(s) will your child need to take during school hours?_____
8. Should any of these medications be administered in a special way? YES NO
   If YES, please explain:_____
9. Should any particular reaction be watched for? YES NO
   If YES, please explain:_____
10. What should be done when your child misses a dose?_____
11. Should the school have backup medication available to give your child for missed dose? YES NO
12. Do you wish to be called before backup medication is given for a missed dose?

SPECIAL CONSIDERATIONS & PRECAUTIONS

Check any special considerations related to your child's epilepsy while at school. *(Check appropriate boxes and describe the impact of your child's seizures or treatment regimen)*

- ❑ General health:
- ❑ Physical functioning:
- ❑ Learning:
- ❑ Behavior:
- ❑ Mood/coping:
- ❑ Other:_____
- ❑ Physical education (gym)/sports:
- ❑ Recess:
- ❑ Field trips:
- ❑ Bus transportation:

GENERAL COMMUNICATION ISSUES

What is the best way for us to communicate about your child's seizure(s)?:_____

Does school personnel have permission to contact your child's physician? YES NO

Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent Signature:_____Date:_____ Dates Updated _____, _____

Physician Signature:_____Date:_____