SEIZURE EMERGENCY ACTION PLAN

School Year_____ Teacher _____

Student's Name_____ DOB_____

Parent/Guardian_____ Cell_____

SEIZURE INFORMATION (*to be completed by physician)*

Seizure Type_____ How it looks_____

Seizure Type_____ How it looks_____

Emergency Medication:

DIASTAT- dosage and instructions: _____

_____

OTHER Med- dosage and instructions: _____

_____

Physician's Printed Name _____ Phone_____

Physician's Signature_____ Date_____

First Aid for Seizures: *(STAY, SAFE, SIDE)*

- **STAY** with the student. **STAY** calm.
- Keep the student **SAFE:**
  - **Protect** their head. Do **NOT** restrain. Do **NOT** put anything in the mouth.
- **TRACK** TIME; turn student on their **SIDE.**

EMERGENCY: IF SEIZURE LASTS FIVE Minutes>>>>>>>>

- **(RN or Trained Personnel) Administer EMERGENCY medication** as indicated by physician's orders.
- **Call 911.**
- **Call** Parents/Guardian.

Parents are required to provide medication to MRCA school nurse prior to the start of school.

Parent/Guardian Signature_____ Date_____

School Nurse Signature_____ Date_____