

# 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? <input checked="" type="checkbox"/>	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)*

- |  |  |
|--|--|
| <input type="checkbox"/> General health:<br><input type="checkbox"/> Physical functioning:<br><input type="checkbox"/> Learning:<br><input type="checkbox"/> Behavior:<br><input type="checkbox"/> Mood/coping:<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Physical education (gym)/sports:<br><input type="checkbox"/> Recess:<br><input type="checkbox"/> Field trips:<br><input type="checkbox"/> 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: \_\_\_\_\_