Merrill Area Public Schools

1111 N. Sales Street Merrill, WI 54452 715.536.4581 Fax 715.536.1788

www.mapsedu.org

*** Student Achievement * Community Partnership * Future Success ***

SEIZURE ACTION PLAN

School Year: 2023-2024

Student: ____ **Date of Birth:** ____________

School: ___________________________ **Teacher:** ___________________**Grade:** ________

Mother / Guardian's Name: ____________________________
Home Address:____________________________________ City / ZIP: ____________________
Home Phone: (____)______________ Cell phone: (____)____________ Pager: (____)_____________
Work Phone: (____)______________Work Hours: ______________________________________

Father / Guardian's Name: _____________________________
Home Address: _____________________________________ City / ZIP: ____________________
Home Phone: (____)______________ Cell phone: (____)____________ Pager: (____)_____________
Work Phone: (____)______________ Work Hours: ______________________________________

Primary Care Physician:____________________ Phone:________________ **Hospital**: ___________

Neurologist:__________________________ Phone:____________________ Nurse: ______________

Seizure Description

Seizure Type:____

Description of Seizure: ____

____

Possible Triggers: ____

Frequency of seizures: _______ per _________. Last date of seizure was _______________________

Average Length of Seizure Activity: ____________ Usual time of day of Seizure Activity:_____________

Average time until Student can return to Regular Activities: ___________________________________

Student's reaction to Seizure:____

Medication

Daily Medication

Name of Medication	Dose	Route	Time of Day	Start Date	Stop Date
1.					
2.					
3.					

Emergency Medication

Name of Medication	Dose	Route	Reason to be given

Merrill Area Public Schools

1111 N. Sales Street Merrill, WI 54452 715.536.4581 Fax 715.536.1788
www.mapsedu.org

* Student Achievement * Community Partnership * Future Success *

SEIZURE ACTION PLAN - CONTINUED

Student: ____ Date of Birth: ____________

First Aid

1. Keep calm and reassure other people who may be nearby.
2. Don't hold the person down or try to stop his movements.
3. Time the length of the seizure with your watch.
4. Clear the area around the person of anything hard or sharp.
5. Loosen ties or anything around the neck that may make breathing difficult.
6. Put something flat and soft, like a folded jacket, under the head.
7. Turn him or her gently onto one side. This will help keep the airway clear. Do not try to force the mouth open with any hard implement or with fingers. **It is not true that a person having a seizure can swallow his tongue.** Efforts to hold the tongue down can injure teeth or jaw.
8. Don't attempt artificial respiration except in the unlikely event that a person does not start breathing again after the seizure has stopped.
9. Stay with the person until the seizure ends naturally.
10. Be friendly and reassuring as consciousness returns.
11. Offer to call a taxi, friend or relative to help the person get home if he seems confused or unable to get home by himself.

Field trips

School personnel will notify family of all field trips in advance and will take the following:

1. Cell phone
2. Copy of the student's management plan.
3. Emergency medication

Parent / Guardian Authorization

I, the parent / guardian of the above named student, understand the health care services stated in the *Seizure Action Plan* will be performed by designated school staff under the training and supervision provided by the school nurses (a registered nurse). I will notify the school in writing if there are any changes in my child's treatment plan. I will provide the necessary medication that needs to be administered during the school day. The Merrill Area Public School District has my permission to contact the student's physician or their designee about this treatment plan. Copies may be shared with the school nurse, trained school personnel and other authorized personnel. This information will become part of your child's school health record and may be shared with Merrill Area Public School staff, Lincoln County Health Department, bus driver(s) and emergency personnel who are responsible for caring for your child while he/she is attending school, summer school, school based or sponsored events, or in an emergency situation. Lincoln County Health Department does not provide health services or oversight for students during any school-based or sponsored events outside of regular school hours. ("Regular School Hours" are defined as school hours that occur from 8 AM to 3 PM, Monday through Friday, from the first to last day of regular instruction which includes summer school.)

Parent / Guardian Signature: ____ Date: _______________

Physician Authorization

I have reviewed and approved the *Seizure Action Plan* for the student named above. I understand that designated school district personnel under the training and supervision provided by the school nurse (a registered nurse will perform specialized health care services). I agree to be contacted by the Merrill Area Public School District with regard to this plan. This consent remains in effect through the end of the school year unless it is discontinued or changed in writing.

Physician Signature: ____ Date: ________________

Physician Address: ____ Phone Number: ________________

Area below for district use:
Date received:________________________________ Reviewed by:_________________________________