Lomira School District
SEIZURE EMERGENCY ACTION PLAN

Students Name:	DOB:	
School Year:	Grade:	Bus Student: Yes No
Parent/Guardian:	Daytime Phone:	

SEIZURE INFORMATION:

Seizure Type	Length	Frequency	Describe signs/symptoms usually seen

- How old was child when seizures started? ________________________________
- What might trigger a seizure? ________________________________
- How does your child act **before a seizure**? ________________________________
- How does your child act **after a seizure**? ________________________________
- How do other illnesses affect seizures? ________________________________

SEIZURE FIRST AID:

Basic Seizure First Aid:
- ✓ Stay calm and note the time
- ✓ Call School Nurse or office: **Ext. 117 or 101 (Lomira)/Ext. 505 or 500 (Theresa) or use radio**
- ✓ Keep child safe, protect head and turn child on his/her side facing you
- ✓ Monitor child
- ✓ Do not restrain child or put anything in his/her mouth
- ✓ Stay with child until fully conscious
- ✓ Notify Parent/Guardian (Office will do)

- In addition to Basic Seizure First Aid, what other action should be taken when child has a seizure?
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SEIZURE EMERGENCY:

A seizure is generally considered an emergency when:
- ✓ A seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without gaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties

A seizure emergency for this child is: ________________________________
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Seizure Emergency Protocol:

☐1. Administer emergency medication listed below ☐2. ***Call 911*** for assistance/ transport
☐3. Other:________________________________
☐

EMERGENCY MEDICATION PLAN:

Medication	Dose	Route	When to use

Medication Consent: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed
I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication.
I further agree to hold the Lomira School District, and its employees who are administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify school at the termination of this request or when any changes in the above orders are necessary.

( ) Yes ( ) No Authorization hereby granted to release this information to appropriate school personnel and teachers.

Physician Signature:	**Date:**
Parent/Guardian Signature:	**Date:**