Botkins Local School

Phone 937-693-4241 Fax 937-693-2557

Seizure Action Plan

To the parents/guardian of:_____Grade_____

According to our records you have informed the school that your child has had seizures. Please complete the information below. This will help the staff know about the seizures your child experiences and the best way to protect the health and safety of your child. Please return this form to the school nurse to add to your child's confidential health record. The nurse will inform all appropriate staff regarding this information.

Is your child aware when a seizure may occur? How?

How long does a seizure last and what occurs?

How does your child act after the seizure?

At what point do you want the school staff to call 911?
Seizure does not stop by itself or with VNS within _____minutes.
Seizure does not stop by itself or with VNS within_____minutes of giving Diastat.
Child does not start to wake up within _____minutes after the seizure is over without Diastat.
Child does not start to wake up within _____minutes after the seizure is over with Diastat given.
Please list all seizure medications, routine and as needed.

Name Dose Frequency

_____
_____
_____
_____

Side effect your child may experience_____

Please list in order of preference contact numbers with a name.
Contact #1_____
Contact #2_____
Contact #3_____
You will be notified if your child has a seizure. Thank you for your cooperation.
Parent/Guardian signature_____Date_____