# Seizure Response Plan

Student's Name | Grade/Teacher

Emergency Contact Information:

Mother/Guardian | Father/Guardian

Home Phone | Work Phone | Cell | Home Phone | Work Phone | Cell

Physician's Name | Physician's Phone

Types of triggers and/or pre-seizure symptoms:

i.e.: triggers – fever, strobe lights, head injury
pre-seizure symptoms: auras, sensory changes

*Specify student's symptoms if applicable*

## Symptoms

### Partial

Abnormal movement of extremity
Abnormal sensory sensations
Elevated heart and respiratory rate
"Deja vu", fearful feeling
Altered consciousness
Other_____

*Circle student's usual symptoms*

### Generalized

Partial symptoms plus:
Altered attention/awareness – blank stare
Eye blinking
Quick severe jerking movements
Vomiting/frothing at mouth
Loss of consciousness
Noisy breathing/groaning/moaning
Loss of bladder and/or bowel control
Loss of pulse and/or breathing
Other_____

*Circle student's usual symptoms*

## Actions Needed

Protect student from harm by: lower student to floor; turn student on side and monitor breathing; clear the immediate area around the student. Make sure there is no furniture (desk, tables, chairs, etc.) that the student could hit and hurt himself/herself on. DO NOT FORCE ANYTHING INTO STUDENT'S MOUTH.

Contact school nurse to activate student's IHP

Activate Medical Response Team if unable to contact school nurse

Call 911 if necessary

I understand that this information will be shared with school personnel on a need-to-know basis.

Parent signature | Date