Ankeny Christian Academy
1604 W 1st St
Ankeny, IA 50023

Seizure Action Plan

Student's Name: : _____ Date of Birth:_____ Grade: _____

Seizure Information:

Seizures look like: _____

Seizure triggers or warning signs: _____

Student response after seizure: _____

Rescue Medication:	Route:	Dose:	When to Give:

First Aid for Any Seizure:
- **STAY calm, begin timing seizure**
- Keep me **SAFE** – remove harmful objects, don't restrain, protect my head
- **SIDE** – turn on side if not awake, keep airway clear, don't put anything in my mouth
- **STAY** until recovered from seizure
- AFTER - write down what happened, call parent and school nurse

When to Call 911:
- Seizure lasts longer than 5 minutes
- Repeated seizures longer than 10 minutes, no recovery in between, no waking up in between
- Difficulty breathing after seizure OR breathing stops during seizure
- Serious injury before, during, or after seizure
- Seizure in water

Any additional information
(Please include details of
most recent seizure-date,
length of time of the
seizure, place,
precipitating factors, etc):

TO BE COMPLETED BY MEDICAL PROVIDER

Practitioner Printed Name: _____ Phone: _____
Clinic/Health care system: _____ Fax: _____
Practitioner Signature: _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I give consent for school personnel to administer medication as described above. I authorize communication between the prescribing health care provider, the school nurse, and trained school personnel necessary for the management and administration of this medication. I have read the ACA Student Handbook and assume responsibilities as required.

Parent/Guardian Signature: _____ Date: _____

TO BE COMPLETED BY SCHOOL STAFF:

Verify all when medication is delivered to school:
- ☐ All above information is completed, including signatures
- ☐ Medication is in original packaging with clear dosing instructions/prescription label.
- ☐ Written instructions above match written instructions on medical packaging.

Staff signature: _____ Date: _____