Loudoun County Public Schools
Seizure Action Plan / Physician's Order

Place Student's Picture Here

Student's Information

Last Name: _____ First Name:_____ DOB:_____

Student ID # _____ School: _____ Grade: _____

Parent/Guardian: _____ Cell: _____ SY: _____

Seizure History

To be completed by a Licensed Healthcare Provider (Physician, Physician's Assistant, or Nurse Practitioner)

Seizure Type (Check all that apply)

Generalized Non-Motor	Generalized Motor:	Focal Seizures
☐ Absence seizure	☐ Atonic (drop) ☐ Tonic/Clonic (grand mal) ☐ Myoclonic	☐ Focal Aware (simple partial) ☐ Focal Impaired (complex partial)

Description of Seizure

Area of Body Involved:	Frequency:	Duration:

Seizure History / Medical Diagnosis:

Seizure Triggers:

☐ Missed Seizure Medication ☐ Lack of Sleep ☐ Emotional Stress ☐ Physical Stress ☐ Missing Meals
☐ Alcohol / Drugs ☐ Flashing Lights ☐ Menstrual Cycle ☐ Illness with high fever
☐ Response to specific food, or excessive caffeine, specify: _____ ☐ Other, specify: _____

Warning Signs - Symptoms that signal a seizure may be starting:

☐ Headache ☐ Staring Spells ☐ Confusion ☐ Dizziness ☐ Change in Vision/Auras
☐ Sudden Feeling of Fear or Anxiety ☐ Strange Smell ☐ Other, specify: _____

Define Seizure Emergency	Emergency Response Plan
A seizure emergency for this student is: ☐ **Continual seizure** lasting greater than _____ minutes ☐ **Cluster:** _____ (# seizures in) _____ minutes ☐ **Other** _____ _____ _____	**Medication/ Instructions/ Actions** **Continual seizure:** ☐ Administer _____ *(name of medication, dose, route)* ☐ Call 911 ✓ Notify Parent **Cluster seizure:** ☐ Administer _____ *(name of medication, dose, route)* ☐ Call 911 ✓ Notify Parent ☐ **Other:** _____ ☐ Call 911 ✓ Notify Parent
	☐ Vagus Nerve Stimulator — Describe magnet use:

Healthcare Provider's Name (Print/stamp): _____

Healthcare Provider's Signature: _____ Date: _____

National Provider Identifier (NPI): _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

My signature gives permission for principal's designee to follow this plan, administer prescribed medication, and contact healthcare provider if necessary. I also agree to pick up any unused medication at the end of the school year. I understand that medication not picked up by a parent/guardian at the end of the school year will be discarded.

Parent/Guardian Signature: _____ Date: _____

SEE REVERSE

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To Be Completed with Health Office Staff
Medication received:_____ Expiration Date: _____
Medication received:_____ Expiration Date: _____
Medication received by:_____/ _____
Health Office Staff Signature/ Date Parent Signature/ Date