CHINO VALLEY
UNIFIED SCHOOL DISTRICT
13461 Ramona Avenue • Chino, CA 91710 • 909.628.1201 • www.chino.k12.ca.us
Student Achievement • Safe Schools • Positive School Climate • Humility • Civility • Service
BOARD OF EDUCATION: Donald L. Bridge • Andrew Cruz • Jonathan E. Monroe • James Na • Sonja Shaw • SUPERINTENDENT: Norm Enfield, Ed.D.

SEIZURE ACTION PLAN (Completed by Physician) – Release of Information

Student Name:_____ Date of birth:_____ Grade:_____

School:_____ School Phone #:_____ Fax #_____

Physician to complete:

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:_____
Student's response after a seizure:_____

BASIC FIRST AID:
Does the student need to leave the classroom after a seizure? ☐ Yes ☐ No

If yes, describe the process for returning student to class_____
_____

EMERGENCY RESPONSE:
A seizure emergency for this student is defined as:_____
_____

Seizure Emergency Protocol: (check all that apply and clarify below)
☐ Call 911 for seizures lasting _____ minutes
☐ Notify parent or emergency contact
☐ Notify doctor
☐ Administer emergency medications as indicated below
☐ Other:_____
_____

Basic Seizure First Aid:
Stay calm & track time
Keep child safe and protect head
Do not restrain or put anything in the mouth
Stay with child until fully conscious
Record in seizure log
Turn child on side
Keep airway open/watch breathing

A seizure is generally considered an emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizure without regaining consciousness
- ✓ Student has a first-time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

**** The physician authorization form must be filled out to have medication on campus****

Medication	Route	Dosage	Frequency

Does the student have a Vagus Nerve Stimulator (VNS)? ☐ Yes ☐ No **if yes, please fill out the Physician Authorization Form for the VNS.
Special Considerations and Safety Precautions:_____

Physician's Name (print): _____ Doctor's stamp
Signature:_____ Date:_____
Address:_____
Office #_____ Fax#_____

I give permission for the health office staff to contact the physician for consultation and exchange of information as needed.
Parent/Guardian Signature: _____ Date:_____

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