SEIZURE ACTION PLAN

Effective Date_____

THIS PARTICIPANT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING CAMP HOURS.

Participant's Name:_____ Date of Birth:_____

Parent/Guardian:_____ Phone:_____Cell:_____

Treating Physician:_____ Phone: _____

Significant medical history:_____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs:_____

Participant's reaction to seizure:_____

BASIC FIRST AID: CARE & COMFORT: *(Please describe basic first aid procedures)*

Basic Seizure First Aid:
- ✓ Stay calm & track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

For tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

Does participant need to leave the group after a seizure? YES ☐ NO ☐
If YES, describe process for returning participant to group

EMERGENCY RESPONSE:

A "seizure emergency" for this participant is defined as:

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

Seizure Emergency Protocol: *(Check all that apply and clarify below)*
- ☐ Contact camp nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other_____

TREATMENT PROTOCOL DURING CAMP HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication

Does participant have a **Vagus Nerve Stimulator (VNS)**? YES NO
If YES, Describe magnet use_____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: *(regarding activities, sports, trips, etc.)*

Physician Signature:_____**Date:**_____

I give my permission for trained Monmouth County Park System staff to administer the above medication.

Parent Signature:_____**Date**:_____