Individualized Seizure Action Plan (ISAP)

PLACE PICTURE HERE

Effective Date:_____Clinic Extension: _____School Nurse/Phone: _____

Student Information

Name:	Date of Birth:	Student ID:
School Name:	Homeroom Teacher/Grade:	
Parent/Guardian Name:	Phone:	
Second Contact Name:	Phone:	
Treating Physician Name:	Phone:	

Seizure Information

Seizure Type	*Length*	*How Often*	*Describe Seizure Symptoms*

How to Respond to a Seizure

Is rescue medication ordered? ☐Yes ☐No Name: _____Dose: _____

When and how to administer rescue medication: _____

_____

Student has a ☐VNS ☐RNS ☐DBS Date Implanted: _____Location of Magnet: _____

*Authorization for Administration of Prescribed Treatment form must be completed by the Provider if student has a device

First aid for seizures:

- Stay calm and track time
- Keep them safe- Remove harmful objects, do not restrain, protect head
- Turn on side if not awake, keep airway clear, do not put objects in mouth
- Stay with them until they are awake and alert
- Other: _____

When to call 911:

- Seizure with loss of consciousness longer than 5 minutes, not responding to rescue medication if available
- Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue medication if available
- Difficulty breathing after seizure
- Serious injury occurs or is suspected
- Seizure occurs in water
- Student has diabetes or is pregnant
- Other: _____

Care After Seizure

What type of help is needed? (describe)_____

When is student able to resume usual activity? _____

Daily Seizure Medication

Medication Name	*Dose*	*When Taken*

Additional Information

Accommodations: (regarding school related activities, class parties, field trips, sports, etc.)

_____

_____

_____

Triggers: _____

Significant Medical History: _____

Allergies: _____

Epilepsy Surgery (type, date, side effects): _____

Diet Therapy (type): _____

Student's ability to manage and understand their epilepsy or seizure disorder: (choose one)
☐ Poor ☐ Developing ☐ Competent ☐ Expert ☐ Other _____

Special Instructions:

_____

_____

_____

_____

Must be Signed by Healthcare Provider and Parent/Guardian

Provider Signature:	Date:
Parent/Guardian Signature:	Date: