Date: [Insert Date]

To: [School Name/School Nurse/Principal]
From: [Physician Name/Clinic Name]
Re: Seizure Action Plan for [Student Name]
Date of Birth: [Student DOB]

To Whom It May Concern,

[Student Name] is currently under my care for a seizure disorder. This letter outlines the necessary protocols and accommodations required to ensure the student's safety while at school.

1. Seizure Description

Type of Seizure: [e.g., Tonic-Clonic, Absence, Focal]
Typical Signs: [e.g., Staring, shaking, loss of consciousness, repetitive movements]
Typical Duration: [Insert duration]

2. Emergency Protocol (Basic First Aid)

- Stay calm and track the time the seizure started.
- Keep the student safe; move hard objects away and protect the head.
- Do not restrain the student.
- Do not place anything in the student's mouth.
- Turn the student on their side if they are not awake or are vomiting.

3. When to Call 911

Emergency medical services should be contacted if:

- A seizure lasts longer than [Number] minutes.
- The student has repeated seizures without regaining consciousness.
- The student is injured or has difficulty breathing after the seizure.
- This is the student's first known seizure.

4. Medications

Daily Medication (at home): [List medication if applicable]
Rescue Medication (at school): [Name of medication, Dosage, and Administration Instructions]

5. Post-Seizure Care

After a seizure, the student may experience [e.g., fatigue, confusion, headache]. Please allow the student to rest in the nurse's office. Contact the parents immediately following any seizure activity.

6. School Accommodations

- [e.g., Avoid flickering lights or specific triggers]
- [e.g., Supervision during swimming or high-risk physical activities]
- [e.g., Extra time for assignments following a seizure event]

Physician Signature: _____
Clinic Phone Number: [Insert Phone Number]
Parent/Guardian Contact: [Insert Parent Phone Number]