Seizure Action Plan

Student Name:_____DOB:_____
Weight: _____ School Year:_____
School:_____ Teacher:_____
Known Allergies:_____

Parent/Guardian Information

Mother's Name_____Father's Name_____
Home#_____Home#_____
Mobile/other_____Mobile/Other_____

Seizure History

When did your child have their first seizure? _____
How frequently does your child have seizures? _____
When was your child's last seizure? _____
Are there any possible triggers? _____
Are there any possible warning and/or behavior changes prior to the seizure?_____

Seizure Information

What do your child's seizures look like?_____
_____
_____
How long do seizures generally last?_____
Average frequency :_____(daily, weekly, monthly,yearly)
Date of last seizure_____
Is there a difference between past and current seizure patterns?_____
If so, how have they changed?_____
_____
How do other illnesses affect your child's seizures?_____
_____

Medication Information What medication does your child take?

Medication	Dosage	Frequency

What do you do when your child misses a dose of medication at home?
_____
Should the school have medication to give your child for a missed dose?____
How often does your child see the doctor regarding seizures?_____
When was your child's last appointment?_____
Who is the physician treating your child's seizures?
Dr.'s Name _____ Phone #_____

School Plan

Has your child been prescribed emergency medication for prolonged seizures?_____ What medication?_____
Will you be sending this medication to school?_____
(separate form is required for emergency medication)
*Please note: if emergency medication is not available at school we will call 911 for prolonged seizures**.***

First aid if seizures occur at school_____
_____
_____
_____
_____
_____
_____
What is the best way to communicate with you seizure activity when it occurs during the school day? _____
_____
_____

Other Comments_____
_____
_____
_____

Completion of this Care Plan authorizes Student Health Services to discuss the health care plan with the physician and the appropriate school staff via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child. I **release the school, the school board and any school employee from any liability for following this care plan.**

Parent/Guardian signature:_____ Date:_____
Physician signature_____ Date:_____