Seizure Action Plan for School

Student Name _____ DOB_____

Physician _____ Phone _____

Emergency Contacts

Name	Relationship	Phone Number(s)
1.		
2.		

Type of seizure: _____

What does the seizure look like and how long does it usually last? _____

_____

Possible triggers that should be avoided: _____

_____

Does the student need any physical activity adaptations/protective equipment (ex. helmet) at school?

_____ No _____ Yes (explain) _____

_____

Is student allowed to participate in physical education and other activities?

_____ No _____ Yes (explain) _____

_____

Are medications taken everyday at home to control the seizures?

_____ No _____ Yes (what medication and dose)_____

_____

Physician's Order

If symptoms are _____

Administer (medication, dose, route) _____

_____

Physician Signature _____ **Date** _____

I want this plan implemented for my child, _____ in school. I hereby give my permission for exchange of confidential information contained in the record of my child between the nurse and physician and my signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

Parent/Guardian Signature _____