



PEN #

SEIZURE Action Plan

Form D

Refer to Medical Information Form

STUDENT INFORMATION

☐ Wears Medic Alert ID

Student Name _____ BD year/month/day _____ Parent/Guardian Name _____
Parent/Guardian Home Phone # _____ Parent/Guardian Business Phone # _____
Emergency Contact Name/Phone # _____ Physician Name/Phone # _____

My child's main seizure triggers are: _____

Does your child have any warning symptoms before a seizure? If yes, what are they? _____

What happens during a seizure? _____

What care do you want your child to have following a seizure? _____

How often does a seizure happen? _____

When was the last seizure? _____

At what point should an ambulance take your child to a hospital? Standard procedure is to call 911 after five minutes of seizure activity. _____

MEDICATIONS:

<u>Medication Name</u>	<u>Dosage</u>	<u>Times</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Guardian Signature _____ Date Completed _____

Dates Reviewed by Parent/Guardian _____

Copies to: _____ Parent(s) _____ School Health Resource Binder (red binder)
_____ Nursing Support Care Plan (if necessary) _____ Student's Emergency Kit

