STUDENT SEIZURE ACTION PLAN
Health Services Department

Tri County Schools

Student Name:_____ ID#:_____ Grade: _____

INFORMATION FOR PARENTS AND GUARDIANS

If the condition named above affects your child, we request that you complete, sign, and return this form to the school health office.

- Sharing this information is important to keeping your child safe, and providing correct emergency response, at school.
- It is very important we have current emergency contact information for you.
- Written authorization from your child's physician is required for medically necessary cares at school (if any needed, including medications). New authorization is needed for each school year and when medical orders change.
- The school nurse may contact you or your child's physician if additional information or clarification is needed for cares at school.
- Information will be shared as appropriate with other school and emergency personnel to benefit your child's safety and success.
- If you have questions, please contact the school nurse at your child's school.

School Nurse: _____ School Phone: _____ Date: _____

Parent/Guardian Name: _____ Phone (H): _____

Address: _____ Phone (W): _____

Parent/Guardian Name: _____ Phone (H): _____

Address: _____ Phone (W): _____

Emergency Phone Contact #1: _____ *Name* _____ *Relationship* _____ *Phone*

Emergency Phone Contact #2: _____ *Name* _____ *Relationship* _____ *Phone*

Physician Student Sees for Treatment of Seizures: _____ Phone: _____

Other Physicians: _____ Phone: _____

Hospital Preference: _____

SEIZURES/HISTORY

Please describe your child's seizures:

_____

_____

_____

Average Length of Seizure: _____ How Often do the Seizures Occur?: _____

Identify conditions that may trigger (cause) the seizure (e.g. noise, blinking lights, etc.):

_____

_____

_____

Emergency room visits or hospitalizations(s) for seizures within the last 3 years? ❑ No ❑ Yes When:

_____

_____

_____

EMERGENCY PLANS FOR SCHOOL STAFF

1. Emergency action is necessary when the student has the following signs and symptoms:
   a) seizure lasting longer than_____ minutes;
   b) or: _____

EMERGENCY MEDICATIONS OR TREATMENTS:

LOCATION OF EMERGENCY MEDICATIONS: ❑ **Health Office** ❑ **Other (describe)**

CONTACT PARENT/GUARDIAN WHEN:

STUDENT TO RETURN TO CLASSROOM WHEN: _____

DAILY MEDICATION PLAN

	Name	Amount	When Given
1.			
2.			
3.			

Comments/Special Instructions:

Parent/Guardian Signature:_____ Date:_____