SEIZURE ACTION PLAN

Student's Name _____ Birthdate _____ Report Date _____

School _____ Teacher _____ P.E. Teacher _____ Grade _____

Dear Parent,

Your child's health record indicates that he/she has epilepsy. Please complete this action plan advising us of any restrictions or considerations regarding physical activity and medication(s). Forms are available through the student health services for your doctor to complete regarding physical education activity and administration of medication.

EMERGENCY INFORMATION

Mother _____ Work _____ Home _____

Father _____ Work _____ Home _____

Physician's name:_____ Phone_____

In case of emergency, contact:

1. _____ Phone _____
2. _____ Phone _____
3. _____ Phone _____

What precipitates your child's seizures?

_____
_____
_____
_____

What <u>symptoms or behaviors</u> related to your child's medical condition(s) might be observed?
Describe <u>appropriate actions</u> to be taken if these symptoms or behaviors occur.

Symptoms and/or Behaviors	Appropriate Actions

Activity restrictions, if any: _____

_____

All Current Medications

NAME OF MEDICATION	DOSAGE	TIME

Medications To Be Given at School (if any).
Medication authorization forms MUST be completed by doctor and parent in order to be given at school.

NAME OF MEDICATION	DOSAGE	TIME

What accommodations may be required during the school day?_____

_____

_____

_____

Additional comments: _____

_____

_____

_____

_____ _____

Parent Signature *Date*