

## SEIZURE DISORDER

*Please provide the school a seizure action plan initiated and signed by the physician*

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Parent / Guardian name and phone number: \_\_\_\_\_

Type of seizure the student has been diagnosed with: \_\_\_\_\_

When was the student diagnosed? \_\_\_\_\_

Date of last seizure: \_\_\_\_\_

Does the student wear an emergency medical bracelet / necklace? \_\_\_\_\_ Yes; which one? \_\_\_\_\_ No \_\_\_\_\_

Is the student currently taking medication to control the seizures? \_\_\_\_\_

Has the student ever had to use an emergency medication to stop a seizure? \_\_\_\_\_ Yes \_\_\_\_\_ No

If YES, when? \_\_\_\_\_

Has the student ever been hospitalized because of seizures? \_\_\_\_\_ Yes \_\_\_\_\_ No

If YES, when? \_\_\_\_\_

What symptoms does the student exhibit when having a seizure? \_\_\_\_\_

How long does the seizure normally last? \_\_\_\_\_

Can the student recognize their symptoms of a seizure coming on? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please list any other chronic medical conditions: \_\_\_\_\_

Please list any other medications the student takes at home: \_\_\_\_\_

Please list any drug allergies: \_\_\_\_\_

Pediatrician and phone number: \_\_\_\_\_

Neurologist and phone number: \_\_\_\_\_

Which hospital do you prefer if your student needs to be transported by emergency services? \_\_\_\_\_

Are you, or someone familiar with your child, able to accompany the student on field trips in case they have a seizure?  
\_\_\_\_\_ Yes \_\_\_\_\_ No

Please list any afterschool activities in which your student will participate during the school year:

Transportation:

Car Rider	Bus Rider
_____ AM _____ PM	_____ AM bus # _____ PM bus #