Seizure Action Plan

School _____

School Year _____ **Date** _____

Student Name: _____ Date of Birth: _____
Teacher: _____ Grade Level: _____
Parents/Guardians: _____
Home Phone: _____ Work Phone (Mother): _____
Cell Phone: _____ Work Phone (Father): _____

Emergency Contact: _____
Name Relationship Phone

Emergency Contact: _____
Name Relationship Phone

Physician: _____ Phone: _____

I understand that it is my responsibility as the parent/guardian of _____ to notify the school nurse/medical professional or designee of any changes in my child's health condition and/or medication/treatment regimen. As parent or legal guardian of the above named student, I understand that my signature on this document authorizes representatives of Henry County Schools to communicate about/receive information regarding my child/ward from my child's physician and his/her staff. I understand that this health information will only be shared with pertinent school staff.

_____ _____
Parent/Guardian Signature Date

Completed by Physician

Seizure Profile:

Type	Precipitating Events	Aura	Frequency	Duration	Prognosis

Has had hospitalization in the past year? _____ If yes, when? _____

Description of Seizure (Kinds of Behavior Observed):
_____
_____

Medication Regimen:

Medication Name	Dosage(Amount)	When to Use

Emergency Services:
_____
_____
_____

Individual Considerations (Please indicate any special diet, physical activity limitations/adaptations, prosthetic devices, special procedures/interventions, and/or impact on school attendance):
_____
_____
_____

_____ _____ _____
Physician Printed Name Physician Signature Date

August 2007