Seizure Action Plan

Student Name: ______________________________ Date of Birth: _________________

Teacher: ___________________________________ Grade: _______________________

Mother/Guardian

Work Phone: _______________________
Home Phone: _______________________
Cell Phone: _________________________
Other: ____________________________

Home Address: ______________________
____
____

Father

Work Phone: _______________________
Home Phone: _______________________
Cell Phone: ________________________
Other: ____________________________

Home Address: ____________________
____
____

Physician Name: ____

Phone Number: ____

Seizure Profile: ____

Description of Seizure:

____
____

Medications:

____
____
____

Action Plan for School:

____
____
____
____

Parent/Guardian Signature: ______________________________ Date: ______________

Physician Signature: ____________________________________ Date: ______________