



Student Health Services

Seizure Action Health Care Plan

Where Students Come First

Student Name: _____ **Date of Birth:** _____

Teacher: _____ Grade: _____ School: _____

Parent/Guardian Information:

Mother's Name: _____ Father's Name: _____

Home #: _____ Home#: _____

Work #: _____ Work #: _____

Mobile/Other: _____ Mobile/Other: _____

Address: _____ Address: _____

Email: _____ Email: _____

Seizure History: _____

Description of Seizure: _____

Medications (Dosage/Frequency-also see Medication Authorization Forms):

Action Plan for School: _____

I am the parent/guardian of _____ and request that the Seizure Action Health Care Plan be utilized during school hours.

School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this Seizure Action Health Care Plan authorizes Student Health Services to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Physician/Health Care Provider Signature: _____ Date: _____

Physician name (print) and phone number: _____

Parent Signature: _____ Date: _____