



# 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: \_\_\_\_\_