Mecklenburg County Health Department
School Health Program

SEIZURE EMERGENCY ACTION PLAN Name: _____

School: _____Year: _____ Grade: _____ Date of Birth: _____ Allergies:_____

Homeroom Teacher: _____ Room: _____ Student ID #:_____

Parent/Guardian: _____ Ph. (H): _____

Address: _____ Ph. (W): _____

Parent/Guardian: _____ Ph. (H): _____

Address: _____ Ph. (W): _____

Emergency Phone Contact #1: _____ _____ _____

Name Relationship Phone

Emergency Phone Contact #2: _____ _____ _____

Name Relationship Phone

Physician treating student for seizure disorder : _____ Phone: _____

Other Physician: _____ Phone: _____

Preferred Hospital: _____

EMERGENCY PLAN (Fill in blanks, cross out and initial any steps not needed for this student.)

Emergency action is necessary when the student has the following symptoms: _____

Daily Seizure Management Plan:

1. What type of seizures does your child have and how often do they occur? _____

   _____

   Date of last seizure: _____

2. Describe your child's symptoms during and after a seizure episode. _____

   _____

3. Does your child have an aura or warning of a seizure coming? Yes __ No __

   Is he/she able to notify anyone that a seizure is coming? Yes __ No __

4. Name medications taken routinely. How often and how much?

   At home: _____

   At school: _____

   Does your child experience any side effects to these medications? Please list:

   _____

   Are there any sports/activities in which your child CANNOT participate?

   _____

*** PLEASE NOTE: If medications are to be taken at school, a Medication Authorization form must be completed by the parent and physician and kept at the school.**

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

This information will be shared with appropriate school staff unless you state otherwise.