Allegheny Valley School District
School Health Services
SEIZURE ACTION PLAN FOR SCHOOL

Student Name ______________________________ D.O.B. ______________ Grade _________

Physician __________________________________ Phone: _____________________________

Emergency Contacts

	Name	Relationship	Number
1.			
2.			

Type of Seizure ____

What does the seizure look like and how long does it usually last? ______________________________

____

Possible triggers that should be avoided: ____

Does the student need any special protective equipment? _____ no _____ yes - (if yes, please explain:)

____

Is the student allowed to participate in physical education and other activities? _____ no _____yes

ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES? ______ No ______ Yes (list medications below)

	MEDICATIONS	AMOUNT TAKEN	HOW OFTEN AND FOR WHAT SIGNS
1.			
2.			

List medication needed at school: (name, dosage/route and frequency)

____

Possible side effects that must be reported to parent or physician: ______________________________

If you have additional comments or care for your child, please describe here________________________

____

____

Physician Signature **Address** **Phone** **Date**

____

Parent/Guardian signature **Date** **Phone**