



Seizure Action Plan

~To Be Completed by Health Care Provider~

General Information:

Child's Name: _____ Today's Date: __/__/____
Child's Date of Birth: __/__/____
Parent/Guardian 1: _____ Phone: (____) ____ - ____
Parent/Guardian 2: _____ Phone: (____) ____ - ____
Primary Health Care Provider: _____ Phone: (____) ____ - ____
Specialty Provider: _____ Phone: (____) ____ - ____

Seizure Information:

Seizure Type	Length	Frequency	Description

Seizure Triggers/Warning Signs: _____

Child's Response after a Seizure: _____

Care and Comfort

Please describe any special care or procedures required during seizure: _____

Does the child need to leave the other children to recover? If yes, describe the process for returning the child to interact with others: _____



Emergency Response:

Please define a “seizure emergency” for this child: _____

Seizure Emergency Protocol (Check all that apply and clarify below):

- Call 911 for transport to _____
- Notify parent or emergency contact
- Administer emergency medications as indicated below
- Notify doctor
- Other _____

Treatment Protocol at School:

Please include daily and *emergency* medications.

Emergency Medication	Medication	Dosage and Time of Day Given	Common Side Effects/Special Instructions

Special Considerations and Precautions

Please describe any special considerations or precautions (regarding activities, sports, trips, etc.): _____

Health Care Provider Signature _____ Date _____

Parent Signature _____ Date _____