Webb City R-7 Schools
Seizure Action Plan

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your student's school nurse.

Student's Name: _____ **Grade**:_____

Parent/Guardian Name: _____ Phone: _____

Other Emergency Contact: _____Phone: _____

Child's Neurologist:_____Phone:_____Location:_____

Child's Primary Care Dr.:_____Phone:_____Location:_____

Significant medical history or conditions:_____

_____

_____

SEIZURE INFORMATION:

1. When was your child diagnosed with seizures or epilepsy: _____

2. Seizure type(s):

Seizure Type	*Average Length*	*Description*

3. What might trigger a seizure in your child? _____

4. Are there any warnings and/or behavior changes before the seizure occurs? YES NO

If YES, please explain: _____

5. How often does your child have a seizure?_____

6. When was your child's last seizure? _____

7. Has there been any recent changes in your child's seizure patterns? YES NO

If YES, please explain: _____

8. How does your child react after a seizure is over? _____

9. How do other illnesses affect your child's seizure control? _____

SEIZURE MEDICATION AND TREATMENT INFORMATION:

10. What medication(s) does your child take?

Medication	*Dosage*	*Frequency/Time*	*Possible Side Effects*

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11. What medication(s) will your child need to take during school hours? _____

12. Should any of these medications be administered in a special way? YES NO

If YES, please explain: _____

13. Should any particular reaction be watched for? YES NO

YES, please explain: _____

14. Does your child have a Vagus Nerve Stimulator? YES NO

If YES, please describe instructions for appropriate magnet use: _____

_____

Parent's Signature: _____Date: _____

Physician Signature:_____ Date:_____