INDIVIDUALIZED HEALTHCARE PLAN
SEIZURES

You have indicated that your child has/had Seizure Activity. So that we can better care for your child while at school, please complete the following Health Information. If you have any questions, call the appropriate nurse's office. Thank You.

Name: _____ DOB: _____

Grade/Homeroom: _____

Parent/Guardian: _____ Home Phone: (___)_____

Address: _____ Mother's Work: (___)_____

Emergency Contact: _____ Father's Work: (___)_____

In case of emergency, I authorize school personnel to contact Physician _____

Phone: _____

Transport via ambulance to: (hospital) _____

Health History

Age of onset: _____ Allergies: _____

Seizure Medications: _____

_____

Other Medications: _____

Related Complications: _____

Other Health Problems: _____

Length of seizures: _____

Events that may precipitate a seizure: _____

Aura (visual, auditory and olfactory) present before seizure _____

- **If seizure lasts longer than 5 minutes, 911 will be notified unless otherwise specified by physcian.**