

**CLOVIS MUNICIPAL SCHOOLS
SEIZURE ACTION PLAN**

STUDENT NAME: _____ GRADE/CLASS: _____

We are providing you with this plan to help faculty and school nurse work with your child's physicians in controlling his/her seizures at school. This plan will be kept in an accessible location at the school.

IN AN EMERGENCY, CONTACT:

Parent/Guardian: _____ Relationship: _____

Phone: (H) _____ (W) _____ (C) _____ (Pager) _____

Parent/Guardian: _____ Relationship: _____

Phone: (H) _____ (W) _____ (C) _____ (Pager) _____

1. How old was this child when he/she had the first seizure? _____
2. When was his/her **LAST** seizure? _____
3. Who is this child's Physician? _____
4. Is this child currently taking any medications or seizures? (please list the medications, time and dosages). _____

5. Child's usual seizure symptoms just before a seizure includes: _____

6. How long does the seizure usually last? _____

7. Describe what usually happens during the seizure activity. _____

8. Have you ever had to call 911 when he/she was having a seizure? _____

*****PLEASE ADD ANY ADDITIONAL INFORMATION TO BETTER HANDLE YOUR CHILD'S SEIZURES AT SCHOOL*****

Doctor Signature

Date

Parent Signature

Date