Seizure Action Plan

Student Name: _____

Teacher: _____

Mother	**Father**
Work Phone: _____	Work Phone: _____
Home Phone: _____	Home Phone: _____
Pager: _____	Pager: _____
Other: _____	Other: _____

Other Emergency Contact: Name _____ Phone _____

Physician Name: _____
Phone Number: _____

Seizure Profile: _____

Description of Seizure: _____

Medications: _____

Action Plan for School: _____

Signature of Parent _____ **Date** _____

Signature of Healthcare Provider _____ **Date** _____