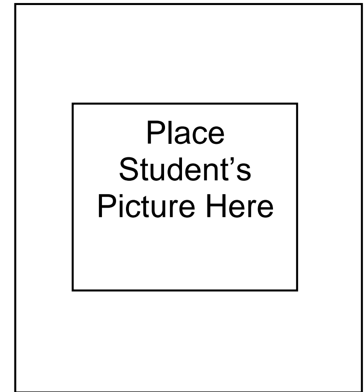
LICKING VALLEY LOCAL SCHOOL DISTRICT

SEIZURE ACTION PLAN



To be completed by Physician

Effective ___/___/___ to ___/___/___

Child's Name____

Address____

Date of Birth_________________________

Room Number_____________ Teacher____________________________

PART 1: Medications taken at **HOME** only:____________________________________

PART 2: I certify that it is essential to the health of this child that medication be administered at school.

A.

Medication	Dosage	When to take	Route to be given

B. Type of Seizure:	**C.** Seizure triggers or warning signs:
Length:	
Frequency:	Child's response to seizure afterwards:
Description:	
Response that should be taken:	

PART 3: Emergency

1. Dr.____Phone:___________________

Emergency Contacts: Name and Phone Number

1:____

2:____

Parent/Guardian Signature_______________________________________Date_____________

Physician Signature____Date______________

Staff Use only Received by:	 Date:

Training Information:

Date	Name	Title	Signature