Seizure Management Sheet

Student's name:______________________________ Grade_____________ Teacher ___________________

Parent/Guardian's Name:____ Phone number:______________

Name of doctor treating seizures: ____Phone:_______________

Name of local pediatrician ____Phone:_______________

My child was diagnosed as having seizures when he/she was _____ years old. The following triggers bring on a seizure:____

____

____

My child wears medical identification? Yes _____ No ______

My child understands what seizures are and what causes them? Yes _____ No _____

My child knows when a seizure may happen? Yes _____ No ______

If my child has a seizure at school the following procedure is to be followed:

1. ____
2. ____
3. ____
4. ____
5. ____

As recommended by his/her physician.

If a seizure occurs at school you will probably see the following:

____

____

My child is currently taking the following medications (include doses) at home:

____ ___________________________

____ ___________________________

____ ___________________________

Please keep my child's teacher updated on his/her seizure care. I will request, from my child's doctor, that the most current reports on my child's condition be sent to the school nurse. I also give permission to the school nurse to speak with his/her doctor as needed along with parent notification.

Next scheduled appointment for follow up is ____________________.

Parent/Guardian's signature ____ Date______________