SEIZURE DISORDER
QUESTIONNAIRE & SCHOOL ACTION PLAN

Child’s Name: _______________________________ Grade: ___________

Type of Seizure Disorder: _______________________________________
How often does child get seizures? ___________________________________
Date of last seizure _____________________________________________

Current Daily Medications:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>How often</th>
<th>At home, At school*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Triggers: Please identify any things that may trigger a seizure:

[ ] Sleep deprivation [ ] Change in medications
[ ] Physical activity or exercise [ ] Dehydration
[ ] Nutritional deficiencies [ ] Fever or illness
[ ] Stress [ ] Other ________________

Warnings or “auras”: Please identify any warning signs your child experiences prior to a seizure:

[ ] Sensory - strange feeling, tingling sensation, or ________________
[ ] Emotional - stress, fear, panic or _____________________________
[ ] Physical - dizziness, headache, lightheadedness, nausea, blurred vision or _________
[ ] No warning signs
# SEIZURE ACTION PLAN

<table>
<thead>
<tr>
<th>IF WE SEE THIS...</th>
<th>We WILL DO THIS....</th>
</tr>
</thead>
</table>
| Student is witnessed having a seizure | 1. Guide student to the floor  
2. Protect his/her head  
3. Call parent/guardian  
4. Call ambulance  
5. Remain with student until ambulance arrives |
| Student becomes unconscious | 1. Start CPR  
2. Call ambulance  
3. Call parent/guardian |

Preferred local hospital: ________________________________

- I authorize school personnel to implement this management and emergency plan as described above.

___________________________  _________________________  
Parent/Guardian’s Signature  Date

If no, please provide separate instructions  ________________________________

______________________________________________________________

______________

rev. 05.12.15