Health Care Plan – Epilepsy

The school is requesting the following information so we can better assist your child should a seizure occur at school.

Information and Contact:

Name: ______________________________ Date of Birth: ________________________
Grade: ______________________________ Classroom teacher: ___________________

Emergency Telephone:

Mother: ______________________________ Father: _____________________________

Seizure Type: __________________

Average length of time seizure lasts: ____
How often seizures occur: ____
Describes student's behaviour following a seizure: ______________________________________
What will trigger a seizure? ____
List any warning signs before the seizure: ____
____

Please list any medications your child receives:
Name of medication: ___________________________ Dose / Time: ___________
Name of medication: ___________________________ Dose / Time: ___________
Name of medication: ___________________________ Dose / Time: ___________
Name of medication: ___________________________ Dose / Time: ___________

My child wears a 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
Allergies (if any): ____

Remarks:
____
____

I hereby give permission to the school nurse to assist with or problem the administration of each prescribed medication for my child during the school days. I understand that it is my responsibilities to notify the school if there is a change in the medication / treatment plan.

________________________ ________________________
Parent's / Guardian's signature Date