PEN #

BOARD OF EDUCATION BURNABY SCHOOL DISTRICT 41

SEIZURE ACTION PLAN (FORM 1D)

STUDENT INFORMATION ☐ **Wears Medic Alert ID**

_____

Student Name BD year/month/day Parent/Guardian Name

_____ _____

Parent/Guardian Home Phone # Parent/Guardian Business Phone #

_____ _____

Emergency Contact Name/Phone # Physician Name/Phone #

My child's main seizure triggers are:_____

_____

Does your child have any warning symptoms <u>before</u> a seizure? If yes, what are they? _____

_____

What happens during a seizure? _____

_____

What care do you want your child to have <u>following</u> a seizure? _____

_____

_____

How often does a seizure happen? _____

When was the last seizure? _____

At what point should an ambulance take your child to a hospital? Standard procedure is to call 911 after five minutes of seizure activity._____

_____

MEDICATIONS:

<u>Medication Name</u>	<u>Dosage</u>	<u>Times</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Guardian Signature _____ **Date Completed** _____

Dates Reviewed by Parent/Guardian _____ _____ _____

Copies to: _____Parent(s) _____School Health Resource Binder (red binder)
_____Nursing Support Care Plan (if necessary) _____Student's Emergency Kit