SIDNEY CITY SCHOOLS

750 S. FOURTH AVENUE
SIDNEY, OHIO 45365
MAIN: 937-497-2200
FAX: 937-497-2211

SEIZURE ACTION PLAN

Student's Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Parent/Guardian's Name: _____ Phone: _____

Provider's Name: _____ Provider's Phone: _____

Provider's Fax Number: _____

According to our records, you have informed the school that your child has had seizures in the past. Please complete the information below. This will help school staff to know more about how your child reacts to his/her medical condition and the best way to protect the health and safety of your child while at school.

Is your child able to know when a seizure may occur?_____How?_____
How long does a normal seizure last? _____
How does your child react after a seizure?_____
At what point would you want 911 to be called?_____

Please list the medications your child takes for seizures (daily medications and as needed).

	Name of medication	Dose	Frequency
(In school)			
(At home)			

Side effects from medication your child may experience:_____
_____

Please list in order the names and phone numbers of the people to contact in the event your child has a seizure in school.

1. Name:_____ Relationship: _____ Number:_____
2. Name: _____Relationship: _____ Number: _____
3. Name: _____Relationship: _____ Number: _____

You will be notified by either the school nurse or designated school personnel when your child has a seizure.

Please contact the public health/school nurse if you have any questions or if your child's medical condition changes during the school year.

_____
Parent/Guardian's Signature Date

Revised 11/24;6/25 Office Use Only - Homeroom/Grade _____