SAINT XAVIER HIGH SCHOOL
SEIZURE ACTION PLAN 2026-2027

If your son is being treated for a seizure disorder, this form must be completed and returned to Student Services.

STUDENT NAME:_____ STUDENT I.D. #_____
Last First Middle

SEIZURE INFORMATION

Seizure type	Length	Frequency	Description

Significant Medical History: _____

_____

Seizure triggers or warning signs: _____

Student's response after a seizure: _____

TREATMENT PROTOCOL (Include daily and emergency medications)

Medication	Purpose	Dosage	Circumstances under which medication must be administered	Route of Administration	Frequency of Administration

Please note: All prescription medications to be taken during the school day should be brought to Student Services accompanied by this form with a signature from your son's health care practitioner. The medicine must be in the original container with the student's and the doctor's names on the bottle.

Does Student have a Vagus Nerve Stimulator? □ **Yes** □ **No**

If YES, describe magnet use: _____

_____ _____
Health Care Practitioner's Signature Date

EMERGENCY CONTACT INFORMATION

_____ _____
Parent/Guardian Phone

_____ _____
Treating Health Care Practitioner Phone

I agree to indemnify, hold harmless, waive and relinquish any and all claims for any injuries my son may have against Saint Xavier High School and its officers, agents, employees, representatives or volunteers arising out of, or in connection with, the distribution of my son's medication as directed by his doctor's or my instruction.

_____ _____
Parent/Guardian Signature Date