FORM D PEN #

BOARD OF EDUCATION BURNABY SCHOOL DISTRICT 41

SEIZURE
Action Plan

Refer to Medical Information Form

Student Photo

STUDENT INFORMATION □ **Wears Medic Alert ID**

_____

Student Name | Birthdate: 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 signs <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>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This agreement must be reviewed when any changes occur to your child's condition.

Parent/Guardian Signature _____Date Completed_____

Dates Reviewed by Parent/Guardian _____ _____ _____

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