



**RE: Seizure Individual Health Plan**

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School Year 25/26

Grade: \_\_\_\_\_ School: CES CMS CHS

Neurologist Name and Phone Number: \_\_\_\_\_

Parent(s)/Guardian(s): \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Health History: \_\_\_\_\_

**STUDENT SEIZURE INFORMATION**

**Type of Seizures:**

Tonic/Clonic Seizures     Absence seizures     Febrile seizures   

Other: \_\_\_\_\_

**Triggers:** What commonly triggers your child's seizures?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Symptoms:** What do your child's seizures look like?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Frequency:**

How often does your child have seizures? \_\_\_\_\_

What time of day do they most often occur?     Morning     Afternoon     Night

Do the seizures start abruptly or gradually? \_\_\_\_\_ How long do the seizures usually last? \_\_\_\_\_

**• My student no longer has this condition and please update their school records**

**Please complete the back side of the form.**

**MEDICATION INFORMATION**

Please list the name(s) of any medications your child uses for his/her seizures:

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Please provide the School with a "Seizure Action Plan" from your provider

Student Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

**MEDICATION REQUIRED DURING SCHOOL HOURS (Please check):**

- Requires treatment with medication for symptoms.  
Medication is in School health office (requires written permission from parent/guardian)
- No treatment required at school.
- This condition is resolved and no longer an issue for my child

**HEALTH CONCERN**

Symptom	Plan/ Action to be taken	Contact Parent? Yes/ No

***All medications must be brought to school in the original container labeled by the pharmacy or with a pharmacy label affixed to the packaging.***

I give permission to the school nurse and other properly trained and authorized staff members of the Creswell School District to perform and carry out the tasks as outlined by my child's Individualized Healthcare Plan. I also consent to the release of the information pertaining to my child's seizure care to the staff members who have custodial care and those who may need to know this information to maintain my child's health and safety during the school day.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_