Seizure Management Sheet

Name _____ Teacher _____
Date of birth _____ Grade _____
Age at diagnosis _____

Parent or Guardian _____ Phone _____
Parent of Guardian _____ Phone _____
Physician _____ Phone _____
Physician _____ Phone _____
Other contact _____ Phone _____

Prevention
Possible triggers

Treatment

Name of medication	Dose	Frequency	Notes

In case of seizure
If a seizure occurs at school, please follow this procedure

If a seizure occurs at school, you may observe the following

Please keep my child's teacher informed about child's seizure disorder.

I give the school nurse permission to communicate with child's doctor if necessary.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____