Seizure Action Plan

Name: _____ Date: _____

DOB: _____ Sex: _____ Student/Employee ID: _____

Guardian: _____ Phone No. _____

Emergency Contact: _____ Phone No. _____

Doctor: _____ Phone No. _____

Current Medications

Name	Purpose	Dosage	Frequency

Allergies

_____

_____

_____

Seizures

Type	Length	Frequency	Triggers/Warning Signs

Basic Seizure Care Instructions

_____

_____

_____

_____

Emergency Seizure Description and Care Instructions

_____

_____

_____

_____

_____