COLQUITT COUNTY SCHOOL DISTRICT
Seizure Action Plan

Student's Name: _____ **Date of Birth**: _____

Teacher: _____

_____ _____

Parent/Guardian: **Parent/Guardian:**

Work Phone: _____ Work Phone: _____
Home Phone: _____ Home Phone: _____
Cell: _____ Cell: _____
Other: _____ Other: _____

Other Emergency Contacts:
Name: _____ Phone: _____
Name: _____ Phone: _____

Physician Name: _____**Phone:** _____

Seizure Profile: _____
_____
_____
_____
_____

Description of Seizure: _____
_____
_____
_____
_____

Medications: _____
_____
_____
_____

Action Plan for School: _____
_____
_____
_____
_____

_____ _____
Parent/Guardian's Signature **Date**

_____ _____
Healthcare Provider's Signature **Date**