Fulton County Schools
Where Students Come First

Student Health Services

Seizure Action Health Care Plan

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

Teacher: _____Grade: _____ School: _____

Parent/Guardian Information:

Mother's Name: _____	Father's Name: _____
Home #: _____	Home#: _____
Work #: _____	Work #: _____
Mobile/Other: _____	Mobile/Other: _____
Address: _____	Address: _____
Email: _____	Email: _____

Seizure History:_____
_____
_____
_____

Description of Seizure: _____
_____
_____

Medications (Dosage/Frequency-also see Medication Authorization Forms):
_____
_____
_____

Action Plan for School: _____
_____
_____
_____

I am the parent/guardian of _____ and request that the Seizure Action Health Care Plan be utilized during school hours.

School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this Seizure Action Health Care Plan authorizes Student Health Services to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Physician/Health Care Provider Signature: _____ Date: _____

Physician name (print) and phone number: _____

Parent Signature: _____ Date: _____

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