LEBANON
COMMUNITY SCHOOL CORPORATION

LCSC Seizure Care Plan

Student's Name: _____Date:___/____/___ DOB: ___/____/___ Age: _____

Parent/Guardian: _____ Email:_____

Phone: _____ (W) _____ (H) _____ (C)

Emergency Contacts:

1._____Phone: _____

2._____Phone: _____

3._____Phone: _____

Family MD: _____Phone: _____

Neurologist: Dr_____ Phone: _____

Significant Medical History or Condition: _____

Allergies: _____ Age student diagnosed with seizures/epilepsy: _____

Seizure Type: _____ Average Length of Seizure: _____ Frequency of Seizures: _____

Possible Triggers: _____ Activity Restrictions after Seizures_____

Any Warning and/or Behavior Changes Prior To the Seizure? _____

When was Student's Last Seizure? _____ Usual Time of Day of Seizure? _____

What to Do When Seizure Occurs: _____

Do We Have Permission to Call 911 if Needed? Yes ☐ No ☐

Current Medications (Please List All Medications)

Name	**Dose**	**Time**	**Possible Side Effects**

Are There Precautions during Fire Drills? YES___ NO__ If Yes, What? _____

Are There Any Limitations for Computer Activities? YES__ NO__ If Yes, Maximum Allowed Time_____

Additional Comments/Care Information_____

Parent/Guardian Signature_____Date_____

Health Services Reviewed _____Date_____
(Signature of Clinic Staff)

Revised 8/21/2017