St. Ignatius
SEIZURE EMERGENCY ACTION PLAN

DOCTOR, PLEASE COMPLETE THE FOLLOWING EMERGENCY PLAN AND FAX TO SCHOOL. THANK YOU

Date:_____

School: St. Ignatius School *Fax Number*: 389-3251

STUDENT'S NAME:_____ DOB:_____

1. Please list all medications currently prescribed specifying dose, frequency, and route: (MUST ALSO COMPLETE MEDICATION ADMINISTRATION FORM FOR EACH MEDICATION TO BE GIVEN DURING SCHOOL DAY, INLCUDING EMERGENCY MEDS.)

2. Please list any specific emergency instructions for this child:

3. Please list any other instructions for school (activity restrictions, diet, etc.):

Last clinic visit:_____ Next clinic visit: _____

Physician Signature:_____

Physician Name: (please print) _____

Date:_____ **Telephone #:**_____

School Nurse Kathy Reder BSN RN

Telephone #: 389-3242 ext. 4

5/15 SzEAP