SEIZURES
INDIVIDUAL EMERGENCY PROTOCOL FOR STUDENTS

Note: Do not complete this form if student is under CCAC nursing care for Seizures.

Name of Student: _____ D.O.B: _____

Parent/Guardian: _____ Phone: _____

_____ Cell phone: _____

Emergency Contact: _____ Phone: _____

Doctor's Name: _____ Phone: _____

Current Medications: (please list)
History of Seizures:
1. Type:
2. Frequency:
3. Typical Duration:
4. Possible Triggers:
5. Symptoms:
Protocol to be implemented by **school staff** during a seizure: **(please note: school staff are unable to administer medication sublingually)**
JMCC School Staff to complete an incident report whenever medical intervention beyond that indicated above is required.

Parent/Guardian signature:		Date:	
Physician's signature:		Date:	
Principal signature:		Date:	

☐ Copy of form in School Classroom, School Office and Medical File

PRINT