Ministry of Education and Child Care

Seizure Action Plan & Medical Alert Information

Student's Name: ______________________ **Date of Birth:** ____________

Seizure Log

Date:		Time started:
Describe what the seizure looked like (include any changes in student's muscle tone, arm/body movements, colour, breathing pattern, loss of bowel/bladder control):		
How long did the seizure last?		Where did seizure occur (location)?
Care/treatment provided: (if rescue medication given, record name of individual that did the double-check)		
Time parent called:		Time 911 called:
Did student return to usual self after the seizure? ☐Y ☐N	Comments:	
Recorder's Name:		Initials:

Date:		Time started:
Describe what the seizure looked like (include any changes in student's muscle tone, arm/body movements, colour, breathing pattern, loss of bowel/bladder control):		
How long did the seizure last?		Where did seizure occur (location)?
Care/treatment provided: (if rescue medication given, record name of individual that did the double-check)		
Time parent called:		Time 911 called:
Did student return to usual self after the seizure? ☐Y ☐N	Comments:	
Recorder's Name:		Initials:

Date:		Time started:
Describe what the seizure looked like (include any changes in student's muscle tone, arm/body movements, colour, breathing pattern, loss of bowel/bladder control):		
How long did the seizure last?		Where did seizure occur (location)?
Care/treatment provided: (if rescue medication given, record name of individual that did the double-check)		
Time parent called:		Time 911 called:
Did student return to usual self after the seizure? ☐Y ☐N	Comments:	
Recorder's Name:		Initials: