



McHenry Elementary School District 15
 1011 N. Green Street, McHenry, Illinois 60050
www.d15.org

SEIZURE TREATMENT PLAN

School:	Date:
Student Name:	Birthdate:
Parent/Guardian:	Phone:
Address:	
Physician Name:	

Medical Information

Seizure Type:
Description of Seizure:
Possible Triggers:
Average Length of Time of Seizure:
Possible Warning and/or Behavior Changes Prior to Seizure:
Student's Post-Seizure Behavior:

Medical Procedures

First Aid Procedures:
Limitations Specified by Physician:
Likelihood/Frequency of Seizures During School Hours:

Medication:

Name of Medication:	Amount/Time Given:
Possible Side Effects:	
Name of Medication:	Amount/Time Given:
Possible Side Effects:	
Name of Medication:	Amount/Time Given:
Possible Side Effects:	

_____ (Physician Signature)	_____ Date
_____ (Parent Signature)	_____ Date
_____ (School Nurse Signature)	_____ Date