Coatesville Area School District Parent/Guardian Questionnaire for Students with Seizures

Stude	nt Name		School	
Schoo	ol Year	Grade	Date	
the ap nurse for yo	propriate care, we immediately. This our child.	request that you complete to information will be used to any change in this informa	child has seizures. In order to give his form and return it to the school o develop an individual action plan tion during the school year, please	
Thanl	x you,			
Certif	ied School Nurse			
1.	Symptoms that student experiences prior to seizure events:			
2.	Frequency of seiz Date of last seizu	re:Len	gth of time:	
Туре	of seizure:			
Descri	ption of seizure:			
5.	Special Instructio	ns:		
6. Name	Medicatio			
Dose		Time:		
	Name of Physician Phone Number			
child. appro		ion to share this plan with i	nn emergency action plan for my my child's assigned teachers and	
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