COLLEGE of CENTRAL FLORIDA
–an equal opportunity college–

ACCESS AND DISABILITY SERVICES
STUDENT SEIZURE RESPONSE PLAN

Academic Year: _____

Legal Name: _____
Last First Middle (complete) Jr., etc.

Mailing Address: _____
Street/P.O. Box City State ZIP Code

Home Telephone No.: _____ **Cell Phone Number:** _____

Instructions specific to the medical condition causing seizures:

Steps that should be taken when I have a seizure:

Type of seizure disorder:

Frequency:

Most recent emergency episode (ambulance, paramedic, hospitalization, etc.)**:**

You know I will be having a seizure when the following happens:

EMERGENCY CONTACT INFORMATION

Contact Name: _____

Relationship: _____ **Telephone:** _____

Contact Name: _____

Relationship: _____ **Telephone:** _____

Contact Name: _____

Relationship: _____ **Telephone:** _____

I give College of Central Florida permission to release this information to the appropriate faculty, staff and/or medical providers so that timely and appropriate assistance can be provided to me in the event of a seizure. I understand that emergency medical personnel, faculty in whose classes I am registered, and CF Security may be provided with a copy of this information, and that it may be deemed necessary to call for outside medical assistance. I am aware that I may refuse such assistance or medical treatment after medical personnel have arrived on campus. I further understand that I am responsible for any expense that may be incurred as a result of medical treatment that has been called or provided for me. I release the College of Central Florida, its employees, officers and trustees from all liability for injury and loss that may occur as a result of my seizure disorder.

Student Signature: _____ **Date** (MM/DD/YY)**:** _____