



**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):** \_\_\_\_\_