



SEIZURE DISORDER INFORMATION

Student: _____ Grade: _____ Teacher: _____

SEIZURE HISTORY

What type of seizures does your child have? Name of diagnosis _____

When was the seizure disorder diagnosed? _____

When was the last time your child had a seizure? _____

Approximately how often does your child have a seizure? _____

Are your child's seizures life-threatening? Yes__ No__

SEIZURE MANAGEMENT

<u>Medication</u>	<u>Dose</u>	<u>Times Given</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes__ No__ Does your child suffer any side effects to these medications?

If yes, describe the side effects _____

Yes__ No__ Does your child use electrical or vagus nerve stimulation therapy?

List surgeries that your child has had related to his/her seizures: _____

TYPICAL SEIZURE PATTERN

Warning Signs: (feelings before seizure, conditions that cause/trigger seizures, behavior changes)

Usually Looks Like: (how long does seizure last, what part/s of body are involved, what does the child look like during the seizure, is breathing affected, when do they occur) _____

After It's Over: (what does the child feel like after a seizure) _____

How do you want the school to treat an episode? _____

How is your child's activity or sports involvement restricted by this condition? _____

What accommodations does your child need at school? _____

What does your child understand about the seizure condition? _____

Does your child understand what s/he can do to manage this condition? Yes__ No__

Does your child have a friend at school that understands this condition? Who? _____

When your child has a seizure, what does s/he call it? _____

Comments (you may use back): _____

Signature of Parent or Guardian _____ Date _____

Family and Emergency Contacts

Name	Relationship	Phone (include area code)	Home/work/cell/pager
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Health Care Provider for Seizures:

Name: _____ Phone: _____ FAX: _____
Hospital/Emergency Room Preference: _____