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

Medication	Dose	Times Given

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 ______________

Form 3691 (5/04) *complete both sides*

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: ____