Updated 09/2019

SEIZURE DISORDER

Name: _____ Date: _____

According to your child's health records, he/she has had one or more seizures. It would be helpful if you could provide us with more information by completing the following questions each year and returning this form to your child's school. Thank You.

****

Seizure Physician's Name: _____ Phone: _____

When was your child's first seizure? _____

What does your child's seizure look like? _____
_____

When was the last seizure? _____

Have the seizures changed from the past? □No □Yes, how? _____

What are possible triggers for seizure activity? (Check all that apply)

Illness_____ Fever ____ _____
Exercise _____ Computer use_____
Video games_____ Environment _____
Drugs _____ Other _____

What medications does your child take currently?

Name _____ Dose _____ Frequency _____
Name _____ Dose _____ Frequency _____
Name _____ Dose _____ Frequency _____

What do you do if your child misses a dose of medication? _____

Does your child have any activity restrictions? _____

Additional comments may be written on the back of this form.

Parent/Guardian Signature: _____ Date: _____

Print Parent/Guardian Name: _____

(R-05-17)

DISTRICT 20 HEALTH SERVICES

Greenbrook Elementary School & Early Childhood Center
630-894-4409 Nurse Phone
630-894-4544 Main Office
630-289-6183 Fax

Waterbury Elementary School
630-894-4211 Nurse Phone
630-893-8180 Main Office
630-539-2316 Fax

Spring Wood Middle School
630-894-4044 Nurse Phone
630-893-8900 Main Office
630-894-9658 Fax