Edmonds School District

HS 40
Student Health Services
Seizure Disorder

Student: _____ **Date**: _____ **DOB:** _____ **Grade:** _____

SEIZURE INFORMATION:

Type of seizure: _____

Description of seizure: _____

_____

Duration of seizure: _____

Average time before returning to regular activities: _____

Ever stop breathing? _____

Possible warning and/or behavior change prior to seizure: _____

_____

_____

Frequency of seizure: _____ □ Dailey □ Weekly □ Monthly □ Yearly

Usual time of day seizure occur: _____ Date of last seizure: _____

When did seizures begin? _____ When diagnosed? _____

Any change in seizure pattern? □ No □ Yes, please describe: _____

_____

Do other illnesses affect your student's seizure control? □ No □ Yes, please describe: _____

_____

MEDICATIONS:

Student currently on medication? □ No, if discontinued when? _____ □ Yes, complete below

MEDICATION	TIME/DAY	DOSAGE	SIDE EFFEECTS

Physician: _____ Phone: _____

How often is student seen? _____ Date of last appointment: _____

Results of last visit/EEG: _____

SPECIAL CONSIDERATIONS

□ Educational concerns: _____

□ Behavior concerns: _____

□ Emotional concerns: _____

□ Physical Education precautions: _____

□ Recess precautions: _____

□ Field trip precautions: _____

□ Special transportation needs: _____

□ Other _____

□ Play on after school sports team/participate in after school activities at school? _____

_____

Parent Signature: _____ Date: _____ Primary Phone:_____

Work Phone: _____ Email: _____

Emergency Contact:_____Relationship:_____ Phone:_____