JERICHO UNION FREE SCHOOL DISTRICT
Jericho, New York 11753
Seizure Questionnaire

Student's Name: _____ Date of Birth: _____
Grade: _____ Home Phone: _____
Mother's Cell: _____ Father's Cell: _____
Neurologist Name: _____ Office Phone: _____
Address: _____

When was your child's first seizure? _____
Describe your child's first seizure?

Has there been any change in the type of seizures your child has? Yes ☐ No ☐
If yes, please describe the change _____
_____
Diagnosis: _____
Current Medications:

_____ _____
_____ _____
_____ _____

Is your child currently having seizures? Yes ☐ No ☐
If yes, how often? _____
When was last seizure? _____
Is your child aware of their diagnosis? Yes ☐ No ☐
If yes, how was it explained to them? _____
_____
Does your child experience any side effects from their medication? Yes ☐ No ☐
If yes, what are they? _____
_____
Does your child have any other medical problems? Yes ☐ No ☐
If yes, what are they? _____
_____
Has your child been hospitalized for a seizure(s)? Yes ☐ No ☐
If yes, when and for how long? _____
_____

_____ _____
Parent / Guardian Signature Date

2-2023