Simi Valley Unified School District
Student Support Services 875 E. Cochran St. Simi Valley, CA 93065 805-306-4500

SEIZURE INFORMATION/CONTACT SHEET

Student _____ Date of Birth _____

School _____ Grade _____

Person completing this form: _____

Please answer the following questions:

1. Type of seizures _____
2. Any known triggers _____
3. Frequency of seizures _____
4. Date of last seizure _____
5. Current medication _____

My child's seizures usually look like this:

_____

_____

_____

If my child has a seizure(s) at school:

- Call 911 if the seizure lasts over _____ minutes or there is breathing difficulty.
- Call 911 if my child has more than _____ seizures in _____ minutes.

The school nurse has my permission to contact the physician if needed.

Name of Physician: _____ Phone: _____

Special instructions:

_____

_____

_____

_____ _____ _____

Parent Signature Phone Date