Seizure

Date:___________

*Please fill out this form and turn it in to your student's secretary. A new form must be completed every school year!

Student Name:____ DOB:_______________________

School:____ Teacher:_________________________

What kind of seizures does your student have? (Please check which apply.)

Generalized Onset Seizure:

Motor Symptoms:
- Clonic (jerking movements)
- Atonic (muscles weak/limp)
- Tonic (muscles tense/rigid)
- Myoclonus (brief muscle twitching)
- Epileptic Spasms (Flexion/Extension repeatedly)

Non-Motor Symptoms (Absence Seizures):
- Typical
- Atypical (staring spells)
- Myoclonus (brief twitching)

Focal Onset Seizure:

Motor Symptoms:
- Clonic (jerking movements)
- Atonic (muscles weak/limp)
- Tonic (muscles tense/rigid)
- Myoclonus (brief muscle twitching)
- Epileptic Spasms (Flexion/Extension repeatedly)
- Automatisms (Repetitive movements)

Non-Motor Symptoms:
- Changes in sensation
- Changes in emotions
- Thinking/cognition changes
- Autonomic functions
- GI sensations
- Waves of heat or cold
- Goosebumps
- Heart racing
- Behavior Arrest (Lack of movement)

Unknown Onset Seizure:

Motor Seizures:
- Tonic-Clonic
- Epileptic Spasms

Non-Motor Seizures:
- Behavior Arrest

Other (please explain):
____
____
____
____
____

How often do seizures occur?: ____ Date of Last Seizure: ___________________

Does your student have a Vagus Nerve Stimulator? Yes:☐ No:☐ Describe use of magnet (if applicable): ______________________

Is your student currently taking medication to control seizures? (If yes, please list medication below.) Yes: ☐ No: ☐

Does your student have emergency medication to be given when having a seizure? Yes: ☐ No: ☐

If yes, what emergency medication does your student have? (Please check which apply.)

Diastat® - a diazepam rectal gel ☐ Nayzilam® - a midazolam nasal spray ☐ Valtoco® - a diazepam nasal spray ☐
Other:_____________________ ☐

Where is your student's emergency medication kept? (Please check which apply.)
At Home: ☐ In Office: ☐ Student Locker: ☐ With Student: ☐

Does your student have any seizure triggers? (Please list below if applicable.) Yes: ☐ No: ☐

Does your student have any warning signs before having a seizure? (Please explain below if applicable.) Yes: ☐ No: ☐

Please list specific instructions for rescue seizure medication below such as how long to wait before giving (if applicable):

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Please list specific care instructions after seizure/after administration of rescue medication below:
Do we have a specific Care Plan/Action Plan from your student's doctor at school? Yes: ☐ No: ☐

*Form continued on back.

Additional Comments: ____
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____
____
____
____

Parent/Guardian Name (printed): ____

Signature:____