



Tidehaven Independent School District

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SEIZURE DISORDER HISTORY FORM

Student's Name _____ DOB _____ Grade _____

Primary Healthcare Provider: _____ Phone: _____

Neurologist: _____ Phone: _____

Does your child have a Section 504 Plan for this health condition? Yes ___ No ___

What age was your child diagnosed with this health condition by a healthcare provider? _____

What type of seizure(s) has your child been diagnosed with? (Check all that apply)

Absence Seizures

Simple Partial Seizures

Atypical Absence Seizures

Complex Partial Seizures

Atonic Seizures

Unknown

Clonic Seizures

Other, describe _____

Myoclonic Seizures

Tonic-Clonic Seizures

Has your child required an emergency room visit or hospitalization due to seizures? Yes ___ No ___

If yes, explain _____

Does your child experience an aura or warning sign before a seizure? Yes ___ No ___

If yes, please describe _____

Describe your child's seizures _____

Does your child lose bowel or bladder control during a seizure? Yes ___ No ___

Are there any limitations to your child's activities? Yes ___ No ___

If yes, explain _____

What is your child's activity like after a seizure? _____

When was the last seizure? _____

Parent/Guardian Name: _____ **Date:** _____

Parent/Guardian Signature: _____

Reviewed by Nurse: _____ Date: _____

Tidehaven ISD does not discriminate on the basis of race, color, age, sex, religion, disability, or national origin.

