

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: _____ ☐ Daily ☐ 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 EFFECTS

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: _____