



Dear Parent,

According to your child's health record, he/she has a history of seizures. Please complete the information below and return it to the school nurse. Thank you.

Child's Name: _____

Physician: _____ **Phone:** _____

What medication is your child currently taking? _____

What side effect, if any, does your child experience from the medication? _____

When and how did you learn of your child's seizure disorder? _____

Has your child ever had a seizure that lasted more than 5 minutes? _____

How do you handle seizures occurring at home? _____

How do you want us to handle seizures occurring at school? _____

When was your child's last seizure? _____

Approximately how often does your child experience seizures? _____

Comments and special instructions.

Parent signature

Date