Student Seizure Information Sheet

(To be completed by parent prior to school entry)

Date: ___________________________ School Year: _____________________ Grade: ____________

Student Name: ___________________________________ Date of Birth: ________________ Age______

Home Room Teacher: ______________________________Room Number: __________

How long has your child had seizures?____

How often do the seizures occur? ____

Has he/she been hospitalized in the past year to treat seizures? (circle one) YES or NO

If yes, when? ____

Who is their physician? ____

Physician phone number: ____

Please describe what happens during the seizure activity:

____
____
____
____
____

What triggers the seizures? (example: noise, blinking lights):

____
____
____

How long does the seizure activity last?

____
____
____

Call 9-1-1 if seizure activity does not stop after ____________ minutes.

Are there any warnings and or behavior changes before the seizure? If yes, please describe:

____
____
____
____

Does your child need any protective equipment (helmet) or activity adaptations at school?
(circle one) YES or NO

If yes, what?

____

____

STUDENT NAME_______________________________ GRADE_________

SCHOOL RECORD OF SEIZURE ACTIVITY

STUDENT: ____

DATE	TIME SEIZURE OCCURED	DURATION

What was the student doing before the seizure?

____

____

What did the student do during the seizure?

____

____

____

____

behavior like after the seizure?

____

____

____

Was the child injured during the seizure?

____

Who was notified?

____

____

Disposition:

remained in class

by _____________________________