Seizure Information for School

Student Name _______________________________ Date of birth ______________ Grade _______

Parent/Guardian _______________________________ Phone ___________ Cell/Work ___________

Physician treating seizures _____________________________________ Phone ___________________

1. When was your child diagnosed with seizures? ____
2. What type of seizures does your child have? ____
3. Do you know what caused the seizures to start? ☐No ☐Yes: ______________________________
4. Has there been a change in the seizure pattern? ☐No ☐Yes: ______________________________
5. How often does your child have seizures? __________________ When was the last one? _________
6. Do you know of anything that triggers a seizure? ☐No ☐Yes: ______________________________
7. Does your child have a warning sign of a seizure? ☐No ☐Yes: ______________________________
8. Describe your child's seizures: ____

   ____

   ____

9. What should school staff do if your child has a seizure? _____________________________________

   ____

10. Does your child have any restrictions because of the seizures or medications?

    ☐No ☐Yes: ____

11. Please list **ALL** the medications your child takes:

Name of medication:	Amount/dose:	When taken:

12. Does your child have any allergies? ☐ No ☐ Yes: _____________________________________
13. Other information or concerns? ____

Parent/Guardian signature:____________________________________ Date: ___________________

Updated 10.21