Seizure History Form

for__________School Year

Student Name: ______________________________________ Date of Birth: ____________ Gender: M / F Grade ____

Parent Contact: _________________________________ Ph. Number: _____________ (home) ___________ (work/cell)

☐ My child has a history of seizures, but has been seizure-free since _____________________________________

☐ My child has been diagnosed with Epilepsy/Seizure Disorder by a licensed healthcare provider.
If so when? ______________________________ Date of most recent seizure? __________________________

Physician/LHP: ___________________________________ Phone: ______________________ Fax: ______________
Neurologist: ______________________________________ Phone: ______________________ Fax:_______________

My child's condition is considered: ☐ Mild ☐ Moderate ☐ Life-Threatening

**** IF YOUR CHILD NEEDS AN EMERGENCY CARE PLAN ON FILE AT SCHOOL, PLEASE FILL OUT THE FOLLOWING:**

Seizure Type: ____ Typical Duration of Seizure: __________________

When was your child diagnosed with Epilepsy/Seizure Disorder: ____

Usual frequency: ____

Describe the warnings of your child's impending seizure: ____
____

Describe your child's seizure activity: ____
____

Post Seizure symptoms: ____
____

What **triggers** your child's seizures?
☐Viral infections
☐Exercise/Overexertion
☐Emotional upset
☐Other: ____

List any limitations or special needs your child may have in school: ______________________________________
____

List **medication(s)** your child will need **at school**: (Medication Authorization Form Required) ____________________
____

List current **medication(s)** your child takes **at home** (include dose and times taken): ______________________
____
____

Parent/Guardian Signature: ____ Date: _________________

Reviewed by R.N. ____ Date: _________________