LAWTON PUBLIC SCHOOLS – SEIZURE HEALTH FORM

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____

Parent/Guardian #1: _____ Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Parent/Guardian #2: _____ Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Emergency Contact: _____ Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Doctor/Health Care Provider: _____ Telephone: _____

Hospital of Choice: □ Comanche County Memorial □ Southwestern □ Reynolds □ Lawton Indian

* Is medication to be administered while student at school? □ Yes □ No
  (If yes, have LPS form #1 completed and turn in to your student's school)

* Has the physician ordered Diastat Rectal Gel (Diazepam) for this student? □ Yes □ No
  (If yes, have LPS form #1 completed and turn in to your student's school)

Please list all medications your child takes related to his/her seizures:

Medication Name	Dosage	Time/How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

* Does the student experience any early warning signs, like an aura, prior to a seizure? □ Yes □ No
  If yes, explain. _____

SEIZURE DIAGNOSIS

Generalized Seizures: □ Tonic Clonic □ Absence □ Myoclonic □ Clonic □ Tonic □ Atonic
Partial Seizures: □ Simple □ Complex □ Secondarily Generalized
□ Other _____

SEIZURE TRIGGERS

Check all that apply: □ Stress □ Fatigue □ Loud Sounds □ Flashing lights □ Heat □ Illness
□ Other _____

SEIZURE SYMPTOMS

Check all that apply: □ Falling down □ Muscle stiffness □ Jerking movements
□ Cries or shouts out □ Loss of bowel/bladder control □ Shaking
□ Lip smacking □ Drooling □ Head turning □ Tongue biting
□ Teeth clenching □ Blank stare □ Twitching of body part _____
□ Purposeless activity □ Other _____

* Frequency of seizures: □ Daily □ Weekly □ Monthly □ Occasional □ Other _____
* How long does the student's seizure typically last? _____
* What is the student's recovery time after a seizure occurs? _____
* What date did the last seizure occur? _____

BEHAVIOR AFTER SEIZURE

Check all that apply: □ Embarrassment □ Withdrawel □ Deep sleep □ Headache □ Confusion
□ Unsteady gait □ Paralysis □ Nausea/Vomiting
□ Other _____

* Are there any restrictions to exercise, recess or P.E.? □ Yes □ No
If yes, explain. _____

* Has the student ever been injured as a result of a seizure? □ Yes □ No
If yes, explain. _____

* Individual considerations for the student. _____

_____

* Does this student's seizures cause him/her to be absent more often from school? □ Yes □ No
If yes, explain. _____

This Seizure Health Form has been approved by:

*** Required***

Physician Name/Title: _____ (Please print or type)

Physician Signature: _____ Date: _____

Telephone: _____ Fax: _____ Address: _____

_____ _____
Parent/Guardian Signature Date