SEIZURE RECORD

Student Name: ____ Date of birth: ____________________________

Parent/Guardian Name: ________________________________ Phone: __________________ Cell: _________________

Treating Physician: _____________________________________ Phone: ____

Diagnosis: ____

1. What type of seizure does your child have, how often do they occur and how long do they last?

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2. Describe your child's symptoms during and after the seizure episode.

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3. Does your child have an aura or warning of a seizure coming? Is she/he able to notify anyone that a seizure is coming?

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4. List seizure medications (anticonvulsants), dose and time taken:

   At home

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   ____

   At school

   ____

   ____

5. Does your child suffer any side effects to this medication? Please list.

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6. Are there any activities in which your child **cannot** fully participate?

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PLEASE READ THE SEIZURE ACTION PLAN FOR SEIZURES ON THE NEXT PAGE

AND ADD ANY FURTHER INSTRUCTIONS THAT YOU WISH FOR YOUR CHILD.