Allegiance STEAM Academy, 5862 C Street, Chino CA 91710
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SEIZURE DISORDER HEALTH HISTORY/UPDATE

To the Parent/Guardian_____Grade _____

Teacher_____

According to our school records, your child has a seizure disorder. The school needs the following information in order to assist your child in case of a seizure. Immediate care may be of an emergency nature. Please complete the following information and return it to the school health office.

Parent/Guardian _____
Home phone _____Cell phone _____ Work_____
Physician /City _____ Phone number _____

1. At what age did the first seizure occur? _____ Was it following a high fever? ___Yes ___ No
Was it in connection with an illness? ___Yes ___ No If yes, please explain_____
_____

2. Approximate date of last seizure _____

3. How frequently does your child have seizures? _____
_____

4. Describe the seizure _____
_____

5. Approximately how long does a seizure last? _____

6. What will trigger a seizure? Are there warning signs? _____
_____

7. Describe your child's behavior following the seizure _____
_____

8. Do you have medication at home to prevent/control the seizures? _____Yes _____No

Name(s) of medication(s)	_____	_____
Dosage(s) of medication(s)	_____	_____
Time medication is given	_____	_____
Date medication was started	_____	_____

9. When was your child last seen by a physician for his/her seizure disorder? _____

10. You will be contacted if your child has a seizure at school. In the event a parent/guardian cannot be reached, please name the person who should be notified, and with whom your child may be sent home, if indicated:

Name _____ Home phone _____
Work phone _____ Cell Phone _____

PLEASE RETURN THIS FORM TO THE HEALTH OFFICE