SEIZURE DISORDER HEALTH HISTORY/UPDATE

(Completed by Parent/Guardian)

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To the Parent/Guardian of _____ Grade _____ Date _____
Home Room/Teacher _____School_____

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

1. At what age did the first seizure occur? _____Was it following a high fever? ☐Yes ☐No
2. Was it in connection with an illness? ☐Yes ☐No If yes, please explain _____
   _____
3. Approximate date of last seizure _____
4. How frequently **does** your child have seizures? ☐Daily ☐Other _____
5. Does your child experience an Aura? ☐Yes ☐No Describe Aura_____
6. Describe the triggers that may bring on seizures: ☐Too much screen time ☐Flashing lights ☐Stress ☐ Exhaustion ☐Other _____
7. Describe the seizure: ☐General convulsions ☐Repetitive movements ☐Staring/blank gaze ☐Change of skin color (pale, blue) ☐Loss of consciousness/fall to ground ☐Labored breathing ☐Dilation of pupils
8. ☐Involuntary loss of urine or feces ☐Vomiting ☐ Other _____
9. Approximately how long does a seizure last? _____
10. Any recent changes in seizure pattern? _____
11. Describe your child's behavior following the seizure _____
12. When was your child last seen by a physician for their seizure disorder? _____
13. Does your child take daily meds at home for seizures? ☐Yes ☐No
14. Does your student participate in before and/or afterschool activities? ☐Yes ☐No If yes, program_____

Date Began	Medication	Dosage	Route	Frequency/Indications for use	Side Effects

15. Does your child have emergency medication prescribed for seizures? ☐Yes ☐No
    If yes, when was it last administered? _____

****Please have your child's physician fill out the physician authorization form for emergency seizure medication****

Date Began	Medication	Dosage	Instructions(Timing/Route)	Actions after Administration

16. Does your student have a VNS? ☐Yes ☐No If yes, please have your physician fill out the physician authorization form for VNS

****Please have your physician fill out the seizure action plan. If a seizure action plan is not submitted, basic seizure first aid will be provided, which may include calling 911 for any seizure activity.**

Print Parent/Guardian Name _____ Signature _____
Contact Phone Number _____ Date _____