# SEIZURE INFORMATION

**Student:** Name_______________________________________________Grade________________

School___________________________________ Teacher__________________________________

**Parent**: Name ________________________________ Phone______________ Work_____________

Emergency Contact/Phone#___________________________________________________________

**Physician's Name & Phone**_________________________________________________________

**Type of Seizures**
____Absence/Staring ____Simple Partial ____Secondarily Generalized
____Atonic ____ Complex Partial Other____________________
____Tonic-Clonic/Grand-mal ____Myoclonic ________________________

**Typical Warning Signs/Aura of Seizure:**
_________________________________________________________________________________

_________________________________________________________________________________

**Please list the medications your child takes for Seizures (include Emergency medications)**

| Name of Medication | Dose | Frequency |
|---|---|---|
| | | |
| | | |
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**<u>If your child will require medication during school hours a school medication form must be completed by the physician & parent.</u>**

**Action to take at school**
____Provide Seizure First Aid until Seizure Stops ______Use Vagal Nerve Stimulator Magnet
____Give Diastat or other Emergency Medication Other_______________________________

***Call 911 if**
____Seizure lasts greater than _______ minutes
____Seizure does not stop within ______ minutes of giving Diastat/Medication
____Student does not start waking up within______ minutes after Seizure
____Call 911 for any seizure activity

**Following a seizure**
____Child should rest in Nurse's office ____Child may return to class
____Parent/Guardian should be notified Other_____________________________

_________________________________________________________________________________
Signature of Parent/Guardian Completing Form Date